

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07480

07456

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18—Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>6 HRS.</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>THOMAS</b> Middle <b>GRIFFITH</b> Last <b>ADAMS</b>  |                                  | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>30</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>DEC. 4, 1888</b> |
| 9. AGE (In years last birthday) yrs.<br><b>78</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>01</b> Days <b>11</b> Hours <b>00</b> Min. <b>00</b>   |   |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED-ACETATE DEPT.</b>  |                                  | 11b. KIND OF BUSINESS OR INDUSTRY<br><b>CELANESE CORP</b>   |   |
| 12. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |                                  | 13. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 14. FATHER'S NAME<br><b>GEORGE ADAMS</b>   |                                  | 15. MOTHER'S MAIDEN NAME<br><b>EDITH GRIFFITH</b>   |   |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |                                  | 17. SOCIAL SECURITY NO. (If yes give war or dates of service)<br><b>214-07-5155</b>   |   |
| 18. INFORMANT<br><b>MRS. ISABEL ADAMS, MT. SAVAGE, MD.</b>   |                                  | Address   |   |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b><br>DUE TO <b>CORONARY SCLEROSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)         |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>ABRUPT</b><br>-----  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , c Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |   |
| 22. ACTUAL SIGNATURE<br><i>Benedict Skitarelic</i> M.D.<br>EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC MD.</b>   |                                  | 23. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <b>Cumberland Md</b> |   |
| 24. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 25. DATE THEREOF<br><b>JULY 2, 1967</b>   |   |
| 26. NAME OF CEMETERY OR CREMATORY<br><b>METHODIST CEMETERY</b>   |                                  | 27. LOCATION (City or Town) (County) (State)<br><b>MT. SAVAGE, MD.</b>  |   |
| 28. FUNERAL DIRECTOR<br><b>JOSEPH R. DURST, SR., FROSTBURG, MD</b>   |                                  | 29. ADDRESS   |   |
| 30. REGD BY REGISTRAR<br><b>JUL 3 1967</b>   |                                  | 31. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |   |

100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b><br/> <b>CERTIFICATE OF DEATH</b> </div>                       |                  |  |                  |  |                                 |   |  |   |  |
|---|------------------|--|------------------|--|---------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)             |                  | c. LENGTH OF STAY IN 1b  |                                 | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE |  | b. COUNTY   |  |
| ALLEGANY  |                  | CUMBERLAND   |                  | 16 DAYS  |                                 | MARYLAND  |  | ALLEGANY  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |                  |  |                  |  |                                 | d. STREET ADDRESS   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| SACRED HEART HOSPITAL   |                  |  |                  |  |                                 | 1011<br>RD #1, HOMEWOOD ADDITION  |  |   |  |
| 3. NAME OF DECEASED (Type or print)   |                  | First  |                  | Middle   |                                 | Last  |  | 4. DATE OF DEATH<br>Month Day Year  |  |
| SARAH   |                  | JANE   |                  | ALBRIGHT   |                                 | JUNE  |  | 24 19 67  |  |
| 5. SEX  | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                   | 8. DATE OF BIRTH |  | 9. AGE (In years last birthday) | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.  |  |
| FEMALE  | WHITE            | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                | 3-27-87          |  | 80 yrs.                         | Months Days Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                  | 10b. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTH PLACE (County & State, or foreign country)           |                                 | 12. CITIZEN OF WHAT COUNTRY?  |  |   |  |
| HOUSEWIFE   |                  |  |                  | Bedford County, Penna.<br>LITTLE ORLEANS, MD.                  |                                 | U.S.A.  |  |   |  |
| 13. FATHER'S NAME   |                  |  |                  | 14. MOTHER'S MAIDEN NAME                                       |                                 |   |  |   |  |
| JOHN ALBRIGHT DIEHL   |                  |  |                  | MARY J. HOOPENGARDNER HOOPENGARDNER                            |                                 |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                  | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT Address  |                                 |   |  |   |  |
| NO  |                  | 220-03-7508  |                  | HOSPITAL RECORD  |                                 |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |                  |  |                  |  |                                 |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |                  |  |                  |  |                                 |   |  |   |  |
| 151X DUE TO ADENOCARCINOMA OF THE STOMACH   |                  |  |                  |  |                                 |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO ABDOMINAL CARCINOMATOSIS  |                  |  |                  |  |                                 |   |  |   |  |
| (c) DUE TO ARTERIOSCLEROTIC HEART DISEASE   |                  |  |                  |  |                                 |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                  |  |                  |  |                                 |   |  |   |  |
| GENERALIZED ARTERIOSCLEROSIS ADVANCED AGE   |                  |  |                  |  |                                 |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |                  |  |                                 |   |  |   |  |
|   |                  | NONE   |                  |  |                                 |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year  |                  | 20d. INJURY OCCURRED   |                  | 20e. PLACE OF INJURY (Home, farm, factory, office bldg., etc.) |                                 | 20f. (City or town) (County) (State)  |  |   |  |
| Hour a.m. p.m. 19   |                  | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>            |                  | NONE   |                                 |   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from JUNE 1, 19 67 to JUNE 24, 19 67, that (I) (we) last saw the deceased alive on JUNE 24, 19 67, and that death occurred at 9:30 PM, from the causes and on the date stated above. |                  |  |                  |  |                                 |   |  |   |  |
| 22a. SIGNATURE  |                  | 22b. DATE SIGNED   |                  | 22c. PHYSICIAN'S NAME (Type)                                   |                                 |   |  |   |  |
| James A. Hallinan M.D.  |                  | 6-25-67  |                  | DR. JAMES P. HALLINAN  |                                 |   |  |   |  |
| 22d. ADDRESS  |                  | 22e. ADDRESS   |                  |  |                                 |   |  |   |  |
|   |                  | 140 BEDFORD ST., CUMBERLAND, MD.   |                  |  |                                 |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                  | 23b. DATE THEREOF  |                  | 23c. NAME OF CEMETERY OR CREMATORY                             |                                 | 23d. LOCATION (City, town or county) (State)  |  |   |  |
| Burial  |                  | 6/27/67  |                  | Fairview Christian Cemetery                                    |                                 | Artemas, Penna.   |  |   |  |
| 24. FUNERAL DIRECTOR  |                  | 25a. REC'D BY REGISTRAR  |                  | 25b. REGISTRAR'S SIGNATURE                                     |                                 |   |  |   |  |
| JOHN J. HAFFER FUNERAL HOME, 230 BALT. AVE.   |                  | DATE JUN 28 1967   |                  | Charles Judge  |                                 |   |  |   |  |

JOHN J. HAGER FUNERAL HOME, 250 E. 1ST AVE.

DR. JAMES F. HALLINAN

140 BEDFORD ST., CUMBERLAND, MD.

2-22-67

JUNE 24, 67

3:30 PM

JUNE 1,

67 JUNE 24,

67

NONE

GENERALIZED ARTERIOCLEROSIS ADVANCED AGE

ARTERIOCLEROTIC HEART DISEASE

10 YRS.

ABDOMINAL CARCINOMATOSIS

2 MO.

ADENOCARCINOMA OF THE STOMACH

2 MO.

NO

250-03-7508 HOSPITAL RECORD

JOHN ALBRIGHT

MARY J. HOSKINS

HOSPITAL

LITTLE ORFELS, MD.

FEMALE WHITE

3-27-7

SARAH

JANE

ALBRIGHT

JUNE

24

67

SACRED HEART HOSPITAL

1001, HENWOOD ADDITION

CUMBERLAND

18 DAYS

CUMBERLAND

ALLBRIGHT

MARYLAND

ALLBRIGHT

07482

CERTIFICATE OF DEATH

07458

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |  | c. LENGTH OF STAY IN TB<br><b>4 months</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Allegany County Infirmary</b>   |  | e. STREET ADDRESS<br><b>Furnace St. Ext.</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Naomi</b> Last <b>Arnold</b>  |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>7</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 3, 1885</b>   |
| 9. AGE (In years last birthday)<br><b>81 yrs.</b>  |  | 10. IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>19</b> Hours <b>67</b> Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Keyser, W.Va.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Stingley Sears</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Leah Kopp</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>220-52-9745</b>  |   |
| 17. INFORMANT<br><b>Raymond F. Arnold</b>  |  | 18. ADDRESS<br><b>1025 Harding Avenue Cumberland, Maryland</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro-Vascular accident</b><br>DUE TO (b) <b>Gen. arteriosclerosis</b><br>DUE TO (c) <b>Hypertension</b>                         |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>yes</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 9, 1967</b> to <b>June 7, 1967</b> that (I) (we) last saw the deceased alive on <b>June 7, 1967</b> , and that death occurred at <b>10:20 A.M.</b> from causes and on the date stated above. |  |  |   |
| 22a. SIGNATURE<br><b>George Simons</b>   |  | 22b. DATE SIGNED   |   |
| 22c. PHYSICIAN'S NAME (Type) <b>George Simons</b>  |  | 22d. ADDRESS<br><b>Memorial Hospital, Cumb., Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>6-9-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Allegany Maryland</b>              |
| 24. FUNERAL DIRECTOR<br><b>H. Lee Silcox</b>   |  | 25a. REC'D BY REGISTRAR<br><b>JUN 9 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

[illegible]

vivo (1997)

**THE UNIVERSITY OF CHICAGO**

## Discussion

2

9-20-78

2124

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~insert~~ give carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07483

CERTIFICATE OF DEATH

07459

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>   |  | c. LENGTH OF STAY IN Tb <b>2WKS. 3DAYS</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>  |  | d. STREET ADDRESS <b>139 ELDER STREET</b>  |  |
| 3. NAME OF DECEASED (Type or print) <b>CLARA VIRGINIA BREIGNER</b>   |  | 4. DATE OF DEATH Month <b>JUNE</b> Day <b>4</b> Year <b>19 67</b>  |  |
| 5. SEX <b>FEMALE</b>   | 6. COLOR OR RACE <b>WHITE</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>9-10-1898</b>  |
| 9. AGE (In years lost birthday) <b>68</b> yrs.   |  | 10. IF UNDER 1 YEAR Months <b>68</b>   | 11. IF UNDER 24 HRS. Days <b>68</b> Hours <b>68</b> Min. <b>68</b>                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HWFE.</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>WESTERNPORT, MD.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>CHARLES SHEETZ</b>  |  | 14. MOTHER'S MAIDEN NAME <b>MARIE PETERS</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>  |  | 16. SOCIAL SECURITY NO. <b>220-03-7515</b>   |  |
| 17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Massive Coronary Thrombosis</b><br>DUE TO<br>(b) <b>Arteriosclerotic Cardio-vascular Disease</b><br>(c) <b>Chronic Rheumatic Heart Disease with block 3°</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept., 1954</b> , to <b>June, 1967</b> , that (I) <b>(x)</b> last saw the deceased alive on <b>June 4, 1967</b> , and that death occurred at <b>2:45 A.M.</b> from causes and on the date stated above.                           |  |  |  |
| 22a. SIGNATURE <b>DR. OVERTON HIMMELWRIGHT</b>   |  | 22b. DATE SIGNED <b>June 4, 1967</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>DR. OVERTON HIMMELWRIGHT</b>   |  | 22d. ADDRESS <b>133 VIRGINIA AVENUE, CUMBERLAND,</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 23b. DATE THEREOF <b>June 7, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md. Allegany MD.</b>              |
| 24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>  |  | 25a. REC'D BY REGISTRAR <b>JUN 9 1967</b>  | 25b. REGISTRAR'S SIGNATURE <b>g Charles Judge</b>  |

07250

DATE OF BIRTH

ALLEGANY

MARYLAND

CHAMBERS

SWITZERLAND

ALLEGANY

CHAMBERS

131 FLOER STREET

MEMORIAL HOSPITAL

CLARK

VIRGINIA

JUNE

WHITE

9-11-1900

USA

WESTERNPORT, MD.

EARL PETERS

CHARLES GARETT

MEMORIAL HOSPITAL, CHAMBERS

As he had the following information

Admission to the hospital

Admission to the hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07484

CERTIFICATE OF DEATH

07460

|  |                                  |   |                                      |   |   |  |   |
|--|----------------------------------|---|--------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |                                  |   |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg</b>   |                                  |   | c. LENGTH OF STAY IN 1b              |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lonaconing</b> 01-1 |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Miners Hospital</b>   |                                  |   |                                      | d. STREET ADDRESS<br><b>Hanekamp Street</b>   |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Erma</b> Middle <b>A.</b> Last <b>Brodie</b>   |                                  |   |                                      | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>6</b> Year <b>19 67</b>  |   |  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/1/1917</b> |   | 9. AGE (In years last birthday)<br><b>49</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                      | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Lonaconing, Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>John Hutcheson</b>   |                                  |   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Bessie DeVault</b>   |   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.   |                                      | 17. INFORMANT Address<br><b>Mr. Robert Brodie Lonaconing, Md.</b>   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4341 Acute pulmonary congestion</b><br>DUE TO (b) <b>Intractable Congestive failure</b><br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  |   |                                      |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs.</b><br><b>7 days</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Primary Carcinoma breast &amp; Pulmonary metastases</b>   |                                  |   |                                      |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |   |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 6, 1967</b> to <b>June 6, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 6, 1967</b> , and that death occurred at <b>12:30 AM</b> , from causes and on the date stated above.   |                                  |   |                                      |   |   |  |   |
| 22a. SIGNATURE <b>L. R. Miles, M.D.</b>  |                                  |   |                                      | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |   | 22b. DATE SIGNED<br><b>6.6.67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. R. MILES, M.D.</b>   |                                  |   |                                      | 22d. ADDRESS<br><b>LONACONING MD.</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>6/8/67</b>  |                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. View Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Moscow A. Md</b>                                       |   |
| 24. FUNERAL DIRECTOR<br><b>George Eichhorn</b>   |                                  |   |                                      | 25a. REC'D BY REGISTRAR<br><b>Lonaconing, Md.</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>William Judge</b>   |   |

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RECORDS OF DEATHS

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G390 7/10/67 pc

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**07485**

**07461**

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission)<br>a. STATE <b>Pennsylvania</b> b. COUNTY <b>Bedford</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>DOA</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Memorial Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Adam</b> Middle <b>H.</b> Last <b>Bruck</b>   |                                  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>30</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>January 6, 1967</b> |
| 9. AGE (In years last birthday)<br><b>92</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>12</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Fairhope, Pa. RD#1</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>USA</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Conrad Bruck</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Frey Bruck</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>200-05-4172A</b>  |  |
| 17. INFORMANT<br><b>Mrs. Anna Ruth Bruck, Hyndman, PA.</b>  |                                  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b><br>DUE TO <b>CORONARY SCLEROSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b><br>(c) <b>---</b>   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>SUDDEN</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>19</b> o.m. <b>---</b> p.m. <b>---</b>  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |  |
| ACTUAL SIGNATURE<br><i>Benedict Skitarelic</i><br>EXAMINER'S NAME (Type)<br><b>BENEDICT SKITARELIC, M.D.</b>  |                                  | 22. DATE SIGNED<br><b>June 30, 1967</b><br>Address (Street, city, town, or county)<br><b>Cumberland, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>July 2, 1967</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hyndman Cemetery</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Hyndman, Bedford Co., Pa.</b>   |  |
| 24. FUNERAL DIRECTOR<br><i>Harvey H. Feigler</i><br>ADDRESS<br><b>Hyndman, Pa.</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>JUL 5 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |                                  |   |  |

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June 11, 1957

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation

Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <div>           1<br/>           07486         </div> <div>           MARYLAND STATE DEPARTMENT OF HEALTH<br/>           DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND<br/>           CERTIFICATE OF DEATH         </div> <div>           07482         </div> </div> |  |  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Allegany</u> <u>MARYLAND</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>McCoole</u> <u>years</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>McMullen Hwy</u>  |  |  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>e. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McCoole</u> <u>01-1</u><br>d. STREET ADDRESS <u>McMullen Hwy</u><br>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Michele</u> <u>Cicchetto</u><br>First Middle Last  |  |  |  |  |  | <b>4. DATE OF DEATH</b> <u>June 27, 1967</u><br>Month Day Year   |  |   |  |  |  |
| <b>5. SEX</b><br><u>Male</u>  |  | <b>6. COLOR OR RACE</b><br><u>White</u>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><u>6 May 1887</u>   |  | <b>9. AGE</b> (In years last birthday) <u>80</u> yrs.<br>IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u><br>IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u> |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Railroad</u>   |  |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Railroad</u>  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Italy</u>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>  |  |  |  |
| <b>13. FATHER'S NAME</b><br><u>Antonio Cicchetto</u>  |  |  |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Francesca Panteleo</u>   |  |   |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)   |  |  |  | <b>16. SOCIAL SECURITY NO.</b>   |  | <b>17. INFORMANT</b><br><u>Margaret Church</u>   |  | Address <u>McCoole, Md.</u>   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral artery disease</u><br>(a), stating the underlying cause last. DUE TO (c)  |  |  |  |  |  |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>5 yrs.</u>  |  |  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>   |  |  |  |  |  |  |  |   |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b>   |  | (County)  |  | (State)  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1962</u> <b>, 19</b> <u>  </u> <b>to</b> <u>6/26/</u> <b>, 19</b> <u>67</u> <b>that (I) (we) last saw the deceased alive on</b> <u>10/18/19</u> <b>, and that death occurred at</b> <u>9:50 P.M.</u> <b>from the causes and on the date stated above.</b>   |  |  |  |  |  |  |  |   |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Harry F. Coffman</u> M.D.   |  |  |  |  |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>   |  | <b>22b. DATE SIGNED</b><br><u>6/30/67</u>   |  |  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Harry F. Coffman, M.D.</u>  |  |  |  |  |  | <b>22d. ADDRESS</b><br><u>537 S. Mineral St. Keyser, W. Va. 26726</u>  |  |   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   |  | <b>23b. DATE THEREOF</b><br><u>1 July 1967</u>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>St. Thomas</u>   |  | <b>23d. LOCATION</b> (City, town or county) <u>Keyser,</u> (State) <u>W. Va.</u>   |  |   |  |  |  |
| <b>24 FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Allen M. Poterch</u>   |  |  |  |  |  | <b>ADDRESS</b><br><u>Keyser, W. Va.</u>  |  | <b>25a. REC'D BY REGISTRAR</b><br>DATE <u>JUL 3 1967</u>  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Charles J. Jule</u>  |  |

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OFFICE OF THE ATTORNEY GENERAL

Allegation

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07487

## CERTIFICATE OF DEATH

07463

|   |   |   |  |   |   |   |   |
|---|---|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |   |   |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |   |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND (RURAL)</b>                               |   |   |   |
| c. LENGTH OF STAY IN 1b<br><b>38 DAYS</b>   |   |   |  | d. STREET ADDRESS<br><b>RT. #5, BOX 361-A, WINCHESTER</b>   |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>SACRED HEART HOSPITAL</b>  |   |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |
| 3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>  |   | First <b>B.</b> Middle <b>COLEMAN</b>   |  | Last <b>COLEMAN</b>   |   | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>9</b> Year <b>1967</b>         |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-5-15</b>                          | 9. AGE (In years last birthday)<br><b>51</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>01</b> Days <b>1</b>                               | IF UNDER 24 HRS.<br>Hours <b>19</b> Min. <b>67</b>                          |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LIFT TRUCK OPERATOR</b>   |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>CELANESE CORP.</b> |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>MIDLAND, MARYLAND</b> |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 13. FATHER'S NAME<br><b>JOSEPH A. COLEMAN</b>   |   |   |  | 14. MOTHER'S MAIDEN NAME<br><b>NETTIE (BUSKIRK) COLEMAN</b>   |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>YES</b>   |   | 16. SOCIAL SECURITY NO.<br><b>214-07-5793</b>   |  | 17. INFORMANT<br><b>HOSPITAL RECORD</b>   |   | 900 PRESTON DRIVE<br><b>CUMB., MD. 21502</b>                                |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple perforations of duodenum - 5411</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pentamides</b><br>(c) <b>10 d.</b> |   |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 d.</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |   |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1948</b> , to <b>9 June, 1967</b> , that (I) (we) last saw the deceased alive on <b>8 June 1967</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.  |   |   |  |   |   |   |   |
| 22a. SIGNATURE<br><i>[Signature]</i>  |   |   |  | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>        |   | 22b. DATE SIGNED<br><b>6/12/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>   |   |   |  | 22d. ADDRESS<br><b>59 GREENE ST., CUMB., MD. 21502</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |   | 23b. DATE THEREOF<br><b>June 12, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |   | 23d. LOCATION (City, town or county) (State)<br><b>Cumberland, Maryland</b> |   |
| 24. FUNERAL DIRECTOR<br><i>[Signature]</i><br><b>John J. Hafer, Jr., 230 Balto Ave. Cumberland,</b>   |   |   |  | 25a. REC'D BY REGISTRAR<br><b>JUN 14 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                            |   |

ALLBANY

MARYLAND

CUMBERLAND (RURAL)

ROAD

RT. 45, BOX 361-A, WINCHESTER

38 DAYS

ALLBANY

CUMBERLAND

SACRED HEART HOSPITAL

WILLIAM

COLEMAN

B.

X

JUNE

21

7-8-12

WHITE

HAIR

CELESTINE CORP.

MIDLAND, MARYLAND

LIFT TRUCK OPERATOR

HETTIE (BUCKING) COLEMAN

JOSEPH A. COLEMAN

200 SETON DRIVE

CUMBERLAND, MD. 21502

HOSPITAL RECORD

21-07-200

YES

20 GREENE ST., CUMBERLAND, MD. 21502

DR. E. E. WEISMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>  |                               | c. LENGTH OF STAY IN 1b <b>4 DAYS 2 1/2 HRS.</b>   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>  |                               | d. STREET ADDRESS <b>229 COLUMBIA STREET</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <b>HAZEL C. COLLINS</b>   |                               | 4. DATE OF DEATH <b>JUNE 18, 1967</b>  |  |
| 5. SEX <b>FEMALE</b>  | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>SEPT. 12, 1913</b> |
| 9. AGE (In years last birthday) <b>53 1/2 yrs.</b>  |                               | 10. IF UNDER 1 YEAR 11. IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HWFE. Owner</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance Agency</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>ROMNEY, W. VA.</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>ALLEN C. CRITES</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>ROSA F. SISK</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |                               | 16. SOCIAL SECURITY NO. <b>UNKNOWN</b>   |  |
| 17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>   |                               | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Peritonitis due to perfor. Append.</b><br>550.1 DUE TO <b>Chronic Uremia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic pyelonephritis</b><br>(c) <b>Acute ammonia, acidosis, azotemia.</b> |                               |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute ammonia, acidosis, azotemia.</b>   |                               |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year <b>19</b>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6-16, 1967</b> to <b>6-18, 1967</b> , that (I) (we) last saw the deceased alive on <b>6-18, 1967</b> , and that death occurred at <b>10:25 PM</b> from causes and on the date stated above.  |                               |  |  |
| 22a. SIGNATURE <b>A. J. Mirkin</b>  |                               | 22b. DATE SIGNED <b>6-20-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>DR. A. J. MIRKIN</b>  |                               | 22d. ADDRESS <b>122 SO. CENTRE ST., CUMBERLAND, MD.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                               | 23b. DATE THEREOF <b>JUNE 21, 1967</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET MEMORIAL PARK</b>  |                               | 23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND, MD.</b>   |  |
| 24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>   |                               | 25a. REC'D BY REGISTRAR <b>JUN 23 1967</b>   |  |
| CUMBERLAND, MD.   |                               | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
07489 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07465

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dawson</b>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dawson</b>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Home Near Dawson</b>   |  |   |  | d. STREET ADDRESS <b>Keyser Route 3</b>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Robert Edwin Crumbaugh</b>  |  |   |  | 4. DATE OF DEATH <b>June 14, 1967</b>  |  |  |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>Jan. 29, 1897</b>                                |  |
| 9. AGE (In years last birthday) <b>70</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>15</b>   |  | IF UNDER 24 HRS.<br>Hours <b>4</b> Min. <b>15</b>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Telegraph Operator</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Frederick, Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                           |  |
| 13. FATHER'S NAME <b>Grayson E. Crumbaugh</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Alice C. Riggs</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW1</b>  |  |   |  | 16. SOCIAL SECURITY NO. <b>236-12-7252</b>   |  |  |  |
| 17. INFORMANT <b>Muriel B. Crumbaugh, (Wife)</b>   |  |   |  | Address  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4201</b> <b>Coronary Occlusion</b><br>DUE TO <b>Coronary Sclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)<br>(c)  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b><br>-----              |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                 |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 14, 1967</b><br>Address (Street, city, town, or country) <b>Cumberland, Maryland</b> |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b>  |  | M.D.  |  | DATE SIGNED  |  |  |  |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic</b>  |  | M.D.  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>6-17-67</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Queens Point Cemetery</b>  |  | 22d. LOCATION (City, town, or country) (State) <b>Keyser, W. Va.</b> |  |
| 23. FUNERAL DIRECTOR <b>Shamash</b>  |  |   |  | 24. REC'D BY REGISTRAR <b>JUN 20 1967</b>  |  |  |  |
| 24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |   |  |  |  |  |  |

2-48250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |   |   |   |  |
|---|--|--|--|---|---|---|---|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |   |   |  |
| 07490   |  |  |  | CERTIFICATE OF DEATH  |   |   | 07466   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND   |  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |   |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |  |  | c. LENGTH OF STAY IN lb<br><b>13 DAYS</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>                                       |   |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>  |  |  |  |   | d. STREET ADDRESS<br><b>14 QUEEN CITY PAVEMENT</b>  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) First <b>CLARA</b> Middle <b>G</b> Last <b>DAVIS</b>   |  |  |  |   | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>18</b> Year <b>1967</b>  |   |   |   |  |
| 5. SEX<br><b>FEMALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>                   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>MAY 23, 1917</b> |   | 9. AGE (In years last birthday) yrs. <b>50</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>OWNER</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>TAVERN</b> |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>ALLEGANY MARYLAND</b>   |   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                              |   |  |
| 13. FATHER'S NAME<br><b>WILLIAM KEMP</b>  |  |  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>ANNIE DEETZ</b>  |   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |  |  | 16. SOCIAL SECURITY NO.<br><b>216 18 1498</b>  |   | 17. INFORMANT<br><b>MEMORIAL AVENUE<br/>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>2040</b> <i>acute exacerbation of chronic</i><br>DUE TO (b) <i>lymphocytic leukemia</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) |  |  |  |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 1/2 yrs</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>  |  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                    |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>1968</b> to <b>6-18</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6-18</b> , 19 <b>67</b> , and that death occurred at <b>4:10 PM</b> , from causes and on the date stated above.  |  |  |  |   |   |   |   |   |  |
| 22a. SIGNATURE<br><i>William P James</i>  |  |  |  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>             |   |   | 22b. DATE SIGNED<br><b>6/21/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR. WM P JAMES</b>   |  |  |  |   | 22d. ADDRESS<br><b>441 NO CENTRE ST. CUMBERLAND, MD.</b>  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE THEREOF<br><b>JUNE 21, 1967</b>          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. PETER &amp; PAUL CEM.</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>CUMBERLAND, MD.</b> |   |  |
| 24. FUNERAL DIRECTOR<br><b>BYRON KIGHT</b>  |  |  |  |   | 25a. RECEIVED BY REGISTRAR<br><b>JUN 23 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                      |   |  |

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UNITED STATES OF AMERICA

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07491.

07467

FOR STATE  
HEALTH DEPT.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |   | c. LENGTH OF STAY IN 1b<br><b>21 years</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Memorial Hospital</b>  |   | d. STREET ADDRESS<br><b>722 Elm Street</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>G.</b> Last <b>Elliott</b>  |   | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>27</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 3, 1945</b>  |
| 9. AGE (In years lost birthday) yrs.<br><b>21</b>   |   | 10. IF UNDER 1 YEAR<br>Months <b>01</b> Days <b>1</b> Hours <b>0</b> Min. <b>0</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Clerk Bureau</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Cumberland, Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Joseph W. Elliott</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Myrtle V. Powell</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>yes 1963-1967</b>   |   | 16. SOCIAL SECURITY NO.<br><b>1963-1967</b>   |  |
| 17. INFORMANT<br><b>Mrs. Myrtle Elliott, Cumberland, Md.</b>  |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intracranial Hemorrhage</b><br><b>8254</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fractured Skull</b><br>DUE TO (c)   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>30 1/2 Hrs.</b><br><b>30 1/2 Hrs.</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Driver of auto involved in a crash</b>                   |  |
| 20c. TIME OF INJURY Month, Day, Year<br><b>2:30 a.m. June 26 1967</b>   |   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Rt. 220, 2 mi. north Cumberland, Alleg. Md</b>   |   | 20f. (City or town) (County) (State)<br><b>Cumberland, Md. Allegany</b>   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |  |
| ACTUAL SIGNATURE<br><b>Benedict Skitarelic</b> M.D.   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type)<br><b>Dr. Benedict Skitarelic, M.D.</b>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>June 27, 1967</b>  |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   | DATE SIGNED   |  |
| Address (Street, city, town, or county)<br><b>Rt. 9 Cumberland</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>June 30, 1967</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland, Md. Allegany</b> |
| 24. FUNERAL DIRECTOR<br><b>James F. Scarpelli, Cumberland, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JUN 30 1967</b>   |  |
| ADDRESS   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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President Eisenhower

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |                                    |  |  |
|--|------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>   |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> <b>01-1</b>   |  |
| c. LENGTH OF STAY IN ID <b>10 years</b>  |                                    | d. STREET ADDRESS <b>109 POLK STREET</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>109 POLK STREET, CUMBERLAND, MD.</b>   |                                    | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Russell</b> Last <b>Elliott</b>   |                                    | 4. DATE OF DEATH Month <b>JUNE</b> Day <b>2</b> Year <b>1967</b>   |  |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b>      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   | 8. DATE OF BIRTH <b>OCT 8 1898</b>   |
| 9. AGE (In years last birthday) <b>68</b> yrs.   |                                    | 10. IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>67</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED EMPLOYEE OF CELANESE CORP. OF AMERICA</b>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY <b>BEDFORD CO. PA.</b>   |  |
| 11. BIRTHPLACE (State or foreign country) <b>USA</b>   |                                    | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>WILLIAM J. ELLIOTT</b>  |                                    | 14. MOTHER'S MAIDEN NAME <b>MAUDE E. (BOORE) ELLIOTT</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |                                    | 16. SOCIAL SECURITY NO. <b>123-10-8988A</b>  |  |
| 17. INFORMANT Address <b>RFD#3 BEDFORD PA.</b>   |                                    | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b><br><b>4201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b><br>(c) <b>"</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |                                    | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.  |                                    | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                    |  |  |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.   |                                    | 22. DATE SIGNED <b>June 2, 1967</b>  |  |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>  |                                    | Address (Street, city, town, or county) <b>Cumberland, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  | 23b. DATE THEREOF <b>5 JUNE 67</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>FELLOWSHIP UNION</b>   | 23d. LOCATION (City, town or county) (State) <b>CENTERTVILLE, PENNSYLVANIA</b> |
| 24. FUNERAL DIRECTOR <b>H. LEE SILCOX</b> ADDRESS <b>404 DECATUR STREET CUMBERLAND MARYLAND</b>  |                                    | 25a. REC'D BY REGISTRAR <b>JUN 6 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07498

07469

|  |                                  |   |   |  |  |
|--|----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Mt. Savage Rural</b>  |                                  |   | c. LENGTH OF STAY IN 1b<br><b>Life</b>  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |                                  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mt. Savage Rural</b>                                 |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Mary Lillian Emerick</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>20</b> , Year <b>1967</b>  |  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 18, 1890</b>  |  | 9. AGE (In years last birthday) <b>76</b> yrs.                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Lonaconing, Md.</b>          |
| 13. FATHER'S NAME<br><b>James Loar</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Fitzpatrick</b>   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                                  |   | 16. SOCIAL SECURITY NO. <b>217-10-1059D</b>   |  |  |
| 17. INFORMANT<br><b>Margaret Emerick, Mt. Savage, Md..RD#1</b>   |                                  |   | Address <b>--</b>   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br>DUE TO<br>Caudilens, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary Sclerosis</b><br>DUE TO<br>(c)   |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><br><b>Years</b>        |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |   |  |  |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.   |                                  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>  |                                  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |
|  |                                  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |
|  |                                  |   | DATE SIGNED <b>6/20/67</b>  |  |  |
|  |                                  |   | Address (Street, city, town, or county) <b>Cumberland, Md.</b>  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>June 23, 1967</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Patrick's Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Mt. Savage, Maryland</b> |
| 23. FUNERAL DIRECTOR<br><b>Anthony Feigler</b>   |                                  |   | 24a. REC'D BY REGISTRAR<br><b>JUN 23 1967</b>   |  |  |
| ADDRESS<br><b>Hyndman, Pa.</b>   |                                  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |   |   |  |   |  |   |  |  |  |  |
|---|--|--|---|--|---|---|--|---|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |   |  |   |   |  |   |  |   |  |  |  |  |
| 07497   |  |  |   |  | 07473   |   |  |   |  |   |  |  |  |  |
| 1. PLACE OF DEATH   |  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) |   |  |   |  |   |  |  |  |  |
| a. COUNTY   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |   |  | a. STATE  |   | b. COUNTY                                    |   |  |   |  |  |  |  |
| Allegheny   |  | Cumberland   |   |  | Maryland  |   | Allegheny                                    |   |  |   |  |  |  |  |
| c. LENGTH OF STAY IN 1b   |  | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)     |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      |   | d. STREET ADDRESS                            |   |  |   |  |  |  |  |
|   |  | 619 N. Centre St. Cumb. Md.  |   |  | Cumberland  |   | 619 N. Centre St                             |   |  |   |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)   |  |  |   |  | 4. DATE OF DEATH  |   |  |   |  |   |  |  |  |  |
| Emma A. Geatz   |  |  |   |  | June 11 1967  |   |  |   |  |   |  |  |  |  |
| 5. SEX  |  | 6. COLOR OR RACE   |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                           |   | 8. DATE OF BIRTH                                    |  | 9. AGE <sup>At years last birthday</sup> <input type="checkbox"/> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. |  |   |  |  |  |  |
| Female  |  | White  |   | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                        |   | July 3, 1894  |  | 72 yrs. Months Days Hours Min.  |  |   |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (County & State, or foreign country) |  | 12. CITIZEN OF WHAT COUNTRY?  |  |   |  |  |  |  |
| Housewife   |  |  |   | —  |   | Cumberland, Md.                                     |  | U.S.A.  |  |   |  |  |  |  |
| 13. FATHER'S NAME   |  |  |   |  | 14. MOTHER'S MAIDEN NAME  |   |  |   |  |   |  |  |  |  |
| Edward O'Neill  |  |  |   |  | Mary Ann Kean   |   |  |   |  |   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |   |  | Address   |  |   |  |  |  |  |
| —   |  |  | —   |  | Joseph E. Geatz   |   |  | Cumberland, Md.   |  |   |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction; Uremia<br>287X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease; Thrombo Phlebitis 14 yr<br>DUE TO (c) Obesity-severe; Gen. osteo-arthritis.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>Generalized arteriosclerosis |  |  |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>6 mo.   |  |   |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>None |   |   |  |   |  |   |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                |   | 20f. (City or town) (County) (State)         |   |  |   |  |  |  |  |
|   |  |  |   |  |   |   |  |   |  |   |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from Jan. 5, 1967 to June 11, 1967, that (I) (we) last saw the deceased alive on 6/11 1967, and that death occurred at 6:25 PM from the causes and on the date stated above.   |  |  |   |  |   |   |  |   |  |   |  |  |  |  |
| 22a. SIGNATURE<br>James P. Hallinan M.D.  |  |  |   |  | 22b. DATE SIGNED<br>6/12/67   |   |  | 22c. PHYSICIAN'S NAME (Type) James P. Hallinan M.D.   |  |   |  |  |  |  |
|   |  |  |   |  | 22d. ADDRESS<br>140 Bedford St. Cumberland, Md.                                       |   |  |   |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE THEREOF   |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City, town or county) (State) |   |  |   |  |  |  |  |
| Burial  |  |  | 6/17/67   |  | St. Patrick's Cem.  |   | Cumberland, Md.                              |   |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Louis Stein Inc. Cumb. Md.  |  |  |   |  | 25a. REC'D BY REGISTRAR<br>JUN 15 1967  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge |  |  |  |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07494

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07470

|  |                                  |   |   |   |  |  |   |
|--|----------------------------------|---|---|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cumberland</u>  |                                  |   |   | c. LENGTH OF STAY IN 1b<br><u>D O A</u>   |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Sacred Heart Hospital</u>   |                                  |   |   | d. STREET ADDRESS<br><u>962 National Highway</u>  |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Anna</u> Middle <u>Catherine</u> Last <u>Ferguson</u>  |                                  |   |   | 4. DATE OF DEATH<br>Month <u>June</u> Day <u>1</u> Year <u>19 67</u>  |  |  |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>1/25/1902</u>  | 9. AGE (In years last birthday)<br><u>65</u> yrs.   | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>                 |  | 11. IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>  </u>  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>           |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U S A</u>  |
| 13. FATHER'S NAME<br><u>Christopher Weires</u>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth Steele</u>   |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |                                  |   | 16. SOCIAL SECURITY NO.<br><u>217-18-4283</u>   |   | 17. INFORMANT<br><u>Mrs. James P. Walton, Route 5, Cumberland, Md</u>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br><u>4201</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>  </u>  |                                  |   |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |   |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>   |                                  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |   |   |  |  |   |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u><br>EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>   |                                  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <u>Cumberland, Md.</u> |   |  |  |   |
| 22. DATE SIGNED<br><u>June 2, 1967</u>   |                                  |   |   |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>1/ 4/67</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Greenmount Cemetery</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Cumberland, Alleg Md</u> |   |
| 24. FUNERAL DIRECTOR<br><u>John J. Hafer, Jr., 280 Balto Ave. Cumberland Md</u>  |                                  |   |   | 25a. REC'D BY REGISTRAR<br><u>JUN 6 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                           |   |

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COLLECTOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07495

CERTIFICATE OF DEATH

07471

|   |                                  |   |  |   |  |   |   |
|---|----------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |                                  |   |  | c. LENGTH OF STAY IN 1b<br><b>7 DAYS</b>  |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>  |                                  |   |  | d. STREET ADDRESS<br><b>2 G JANE FRAZIER VILLAGE</b>  |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROBERT</b> Middle <b>W</b> Last <b>FLEEK</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>6</b> Year <b>19 67</b>  |  |   |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>XXXXX 1-10-98</b>             | 9. AGE (In years last birthday)<br><b>69</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.                            |   | IF UNDER 24 HRS.<br>Hours Min.                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MAINTENANCE WORKER</b>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b> |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>W. VA.</b> |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>ADAM FLEEK</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET CADWALTER</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>UNKNOWN</b>   |  | 17. INFORMANT Address<br><b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1914 CARCINOMATOSIS &amp; METASTASES</b><br>DUE TO <b>TO THE SKULL, BRAIN, PRIMARY</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SITE CARCINOMA OF SCALP</b><br>(c) |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>ARTERIOSCLEROTIC HEART DISEASE; POSSIBLE CARCINOMA OF LUNG</b>   |                                  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1964</b> to <b>6/6</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/6</b> 19 <b>67</b> , and that death occurred at <b>3:30 P.M.</b> from causes and on the date stated above.   |                                  |   |  |   |  |   |   |
| 22a. SIGNATURE<br><b>DR. S. G. WEISMAN</b> M.D.   |                                  |   |  | 22b. DATE SIGNED<br><b>6/8/67</b>   |  | 22c. ADDRESS<br><b>CUMBERLAND, MD.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>JUNE 30, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ECKHART CEMETERY</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>ECKHART MD.</b>                               |   |
| 24. FUNERAL DIRECTOR<br><b>BYRON KIGHT</b>  |                                  |   |  | 25a. REC'D BY REGISTRAR<br><b>JUN 12 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

CERTIFICATE OF DEATH

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND, MD.

17 DAYS

CUMBERLAND

2 G LANE FRATER VILLAGE

2 G LANE FRATER VILLAGE

JUNE 6

FLEE

ROBERT

1944-1-10-55

WHITE

WIFE

U.S.A.

W. VA.

MARGARET CAMPBELL

ADAM FLEE

MOUNTAIN HOSPITAL CUMBERLAND, MD.

CUMBERLAND, MD.

DR. S. C. WEISMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07496

CERTIFICATE OF DEATH

07472

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>7 DAYS</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>   |                                  | d. STREET ADDRESS<br><b>FLINTSTONE (Star Route)</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>HARVEY</b> Middle <b>LESLEY</b> Last <b>FREY</b>  |                                  | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>13</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>1888</b><br><b>12-20-1888</b> |
| 9. AGE (In years last birthday)<br><b>78</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Photo Engraver</b>   |                                  | 11b. KIND OF BUSINESS OR INDUSTRY<br><b>COLORADO</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>COLORADO</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |
| 13. FATHER'S NAME<br><b>DANIEL FREY</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>AUGUSTA STONE</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>064-01-9530</b>   |   |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>  |                                  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS OF BONE MARROW</b><br><b>177X</b><br>DUE TO <b>AND BONES</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CARCINOMA OF PROSTATE</b><br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)<br><b>Arteriosclerotic Heart Disease</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office Bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/67</b> to <b>June 13, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 13, 1967</b> , and that death occurred at <b>12:50 P.M.</b> from causes and on the date stated above.   |                                  |   |   |
| 22a. SIGNATURE<br><b>S. G. Weisman</b> M.D.  |                                  | 22b. DATE SIGNED<br><b>6/15/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR. S. G. WEISMAN</b>   |                                  | 22d. ADDRESS<br><b>59 GREENE ST., CUMBERLAND, MD.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>6/16/67</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Allegany Maryland</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>H. Lee Silcox</b> Cumberland, Maryland 21502  |                                  | 25a. REC'D BY REGISTRAR<br><b>JUN 19 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                  |   |   |

1933

DEPARTMENT OF HEALTH

07133

ALLIANCE

MARYLAND

1 JUL 4

7 DAYS

ELIOTSTONE

MEMORIAL HOSPITAL

HARVEY

FRY

JUNE

1933

WHITE

1933

COLORADO

DANIEL FRY

1933

MEMORIAL HOSPITAL - CHICAGO, ILL.

12:22 P.M.

22 GREENE ST., CHICAGO, ILL.

DR. S. B. WEISS

1933

1933

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07498

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07474

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Ellerslie Rural</b>                       |  |   |  | c. LENGTH OF STAY IN 1b<br><b>Ellerslie Rural</b>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>P. O. Box #1</b>                              |  |   |  | d. STREET ADDRESS<br><b>P. O. Box #1</b>  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>CHARLENE SUE GIBBNER</b>   |  |   |  | 4. DATE OF DEATH <b>June 22 1967</b>  |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 16, 1967</b>  |  |
| 9. AGE (In years lost birthday) yrs.<br><b>22</b>  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Cumberland, Maryland</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>Charles Ray Gibbner</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Esther Benna</b>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  |
| 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br><b>Charles R. Gibbner</b>  |  | Address<br><b>Ellerslie, Md.</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>490X</b><br>IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA</b><br>DUE TO<br>(b) <b>(STREPTOCOCCAL)</b><br>DUE TO<br>(c) <b>(STREPTOCOCCAL)</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>HOURS</b>  |  | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                     |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20f. (City or town) (County) (State)   |  | 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22. DATE SIGNED<br><b>JUNE 22, 1967</b>   |  | 23. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |
| 23b. DATE THEREOF<br><b>June 24, 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hyndman Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Hyndman, Bedford Co., Pa.</b>   |  | 24. FUNERAL DIRECTOR'S NAME (Type)<br><b>BENEDICT SKITARELIC, M.D.</b>   |  |
| 24b. ADDRESS<br><b>Hyndman, Pa.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  | 25c. DATE<br><b>JUN 26 1967</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |                         |   |   |  |  |   |  |   |  |
|---|--|---|-------------------------|---|---|--|--|---|--|---|--|
| 07499   |  |   |                         |   | 07475   |  |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <i>Allegany</i> MARYLAND   |  |   |                         |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i> |  |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Cumberland,</i>  |  |   | c. LENGTH OF STAY IN 1b |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Rt. # 6 Cumberland,</i> 01-1                         |  |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><i>Memorial Hosp.</i>   |  |   |                         |   | d. STREET ADDRESS<br><i>Brant Rd. Cresaptown,</i>   |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><i>James</i>  |  | First<br><i>James</i>   |                         | Middle<br><i>Walter</i>   |   | Last<br><i>Grant</i>   |  | 4. DATE OF DEATH<br>Month <i>June</i> Day <i>26,</i> Year <i>19 67</i>                            |  |   |  |
| 5. SEX<br><i>Male</i>   |  | 6. COLOR OR RACE<br><i>White</i>  |                         | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><i>March 17, 1924</i>  |  | 9. AGE (In years last birthday)<br><i>43</i> yrs.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Driver-Salesman</i>   |  |   |                         | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Dairy</i>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><i>Beryl, W. Va.</i>        |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>   |  |   |  |
| 13. FATHER'S NAME<br><i>Charles R. Grant</i>  |  |   |                         |   | 14. MOTHER'S MAIDEN NAME<br><i>Eva Burke</i>  |  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><i>Yes,</i>  |  | 16. SOCIAL SECURITY NO.<br><i>W. W. # 2</i>   |                         | 17. INFORMANT<br><i>Mrs. Pauline Grant,</i>   |   | Address<br><i>Rt. # 6 Cumberland, Md.</i>  |  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i><br><i>442X</i><br>DUE TO (b) <i>Hypertensive cardiovascular renal disease</i><br>DUE TO (c) <i>Arteriosclerosis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><i>Diabetes mellitus</i> |  |   |                         |   |   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>6 hours</i><br><i>10 years</i> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |                         | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. <i>19</i>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |                         | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>19 50</i> , to <i>6/25/67</i> , that (I) (we) last saw the deceased alive on <i>6/25/67</i> , and that death occurred at <i>2:20</i> M, from the causes and on the date stated above.  |  |   |                         |   |   |  |  |   |  |   |  |
| 22a. SIGNATURE<br><i>[Signature]</i>  |  |   |                         | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |   | 22b. DATE SIGNED<br><i>6/27/67</i>   |  |   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><i>S. G. WEISMAN MD</i>   |  |   |                         | 22d. ADDRESS<br><i>59 Green St Cumberland Md</i>  |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE THEREOF<br><i>6/28/67</i>   |                         | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Eckhart Cemetery</i>   |   | 23d. LOCATION (City, town or county) (State)<br><i>Eckhart, Allegany, Maryland</i> |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>H. Wayne George Cumberland, Maryland</i>   |  |   |                         |   | 25a. REC'D BY REGISTRAR<br><i>JUN 29 1967</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |   |  |   |  |

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James H. Johnson

CONFIDENTIAL

Copyright Clearance Center

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07500

CERTIFICATE OF DEATH

07476

|   |                                  |   |                                     |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>8/6/1966</b>  |                                     |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Oldtown,</b>   |                                  | d. STREET ADDRESS<br><b>Route #4</b>  |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Allegany County Infirmary</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Virginia Marie Hartley</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>June 27, 19 67</b>   |                                     |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1/4/1898</b> |
| 9. AGE (In years last birthday)<br><b>69</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                     |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>West Virginia</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                                     |
| 13. FATHER'S NAME<br><b>John Buser</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Delcie Boggs</b>   |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>111-24-9396</b>   |                                     |
| 17. INFORMANT <b>P.O. Box 599, Cumberland, Md.</b>  |                                  | <b>Allegany County Infirmary records.</b>   |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Crohn's with starvation</b><br>DUE TO <b>443X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocardial Insufficiency</b><br>DUE TO (c) <b>Chronic A.S.C.V.D. with Hypertension</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>approx. 2 mo.</b><br><b>approx. 1 yr.</b><br><b>approx. 10 mo.</b>   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Man. A.S. Diabetes Mellitus - C.V.A. - June '66</b>  |                                  |   |                                     |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>8/6/1966</b> , 19 <b>67</b> , to <b>6/27/1967</b> , that (I) (we) last saw the deceased alive on <b>6/27/1967</b> , 19 <b>67</b> , and that death occurred at <b>P.</b> M., from causes and on the date stated above.  |                                  |   |                                     |
| 22a. SIGNATURE<br><b>John A. Topper, M.D.</b>   |                                  | 22b. DATE SIGNED<br><b>6/28/1967</b>  |                                     |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John A. Topper, M. D.</b>  |                                  | 22d. ADDRESS<br><b>Memorial Hospital, Cumberland, Md.</b>   |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>6/30/1967</b>   |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glendale Brethren Cem</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Flintstone Allegany Md.</b>   |                                     |
| 24. FUNERAL DIRECTOR<br><b>John J. Hafer, Jr., 230 Balto Ave., Cumberland Md</b>  |                                  | 25. RECORD BY REGISTRAR<br><b>John J. Hafer, Jr.</b>  |                                     |
| 26. REGISTRAR'S SIGNATURE<br><b>John J. Hafer, Jr.</b>  |                                  | 27. REGISTRAR'S SIGNATURE<br><b>John J. Hafer, Jr.</b>  |                                     |

07270

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Allegany

Allegany

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Allegany

Allegany County Infirmary

Allegany

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ST. 67

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1/1/1908

West Virginia

West Virginia

John Baker

John Baker

Allegany County Infirmary, M.D.  
P.O. Box 2-1, Cumberland, Md.

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Memorial Hospital, Cumberland, Md.

John A. Tooper, M.D.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07501

07477

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FROSTBURG</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>42 DAYS</b>   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FROSTBURG</b>   |                                  | d. STREET ADDRESS<br><b>55 CENTENNIAL STREET</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MINERS HOSPITAL</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>EDGAR L. HARVEY</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>JUNE 29, 19 67</b>   |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>DEC. 12, 1893</b> |
| 9. AGE (In years last birthday)<br><b>73</b> yrs.  |                                  | 10. IF UNDER 1 YEAR Months Days Hours Min.<br>IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED FLORIST</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN BUSINESS</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>MARYLAND</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>EDWIN J. HARVEY</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>CLARA EVANS</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>218-30-2484</b>   |  |
| 17. INFORMANT<br><b>DANE HARVEY, 340 ALLEGANY ST., FROSTBURG, MD</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerosis C.V.D.</b><br>4221 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Heart Failure</b><br>DUE TO<br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>20 yrs.</b><br><b>3 mos.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>AUG. 1966</b> , to <b>29 JUNE 1967</b> , that (I) (we) last saw the deceased alive on <b>29 JUNE 1967</b> , and that death occurred at <b>11:15 PM</b> , from causes and on the date stated above.  |                                  |   |  |
| 22a. SIGNATURE<br><b>Martin M. Rothstein</b>   |                                  | 22b. DATE SIGNED<br><b>6/30/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>MARTIN M. ROTHSTEIN M.D.</b>  |                                  | 22d. ADDRESS<br><b>48 BROADWAY - FROSTBURG, MD. 21532</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 23b. DATE THEREOF<br><b>JULY 1, 1967</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>FBG. MEMORIAL PARK</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>FROSTBURG, MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>JUL 3 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                  |   |  |

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VR A15 (4)  
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |   |   |   |   |   |  |  |  |  |  |  |  |  |
|---|--|---|---|---|---|---|---|--|--|--|--|--|--|--|--|
| 07502   |  |   |   |   | CERTIFICATE OF DEATH  |   |   |  |  | 07478  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b>  |  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |   |   |  |  |  |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lonaconing</b>   |  |   |   |   | c. LENGTH OF STAY IN 1b<br><b>1 yr.</b>   |   |   |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Westernport</b> |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Kyle Nursing Home</b>  |  |   |   |   | d. STREET ADDRESS<br><b>Green St.</b>   |   |   |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>John</b> First <b>J.</b> Middle <b>Healy</b> Last   |  |   |   |   | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>8</b> Year <b>1967</b>   |   |   |  |  |  |  |  |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>white</b>              |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>Dec. 5, 1981</b> |   | 9. AGE (In years last birthday)<br><b>85</b> yrs.                              |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | IF UNDER 24 HRS.<br>Hours Min.             |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Car Repairman</b>   |  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Rail Road</b>   |   |   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Piedmont, W. Va.</b> |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  |  |  |
| 13. FATHER'S NAME<br><b>Dennis Healy</b>  |  |   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Brown</b>   |   |   |  |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>705-09-7072</b> |   | 17. INFORMANT<br><b>Mary Luteman</b>  |   | Address<br><b>Morgantown, W. Va.</b>    |   |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br><b>11201</b> DUE TO <b>Coronary Insufficiency</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO <b>Arteriosclerosis - generalized</b><br>(b) (c) |  |   |   |   |   |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |   |   |   |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |   |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                      |  |  |  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1967</b> , to <b>June 8, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 6, 1967</b> , and that death occurred at <b>7 P.M.</b> , from the causes and on the date stated above.   |  |   |   |   |   |   |   |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><b>L.R. Miles Jr</b>  |  |   |   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>        |   | 22b. DATE SIGNED<br><b>6-9-67</b>   |  |  |  |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L.R. MILES JR</b>  |  |   |   |   | 22d. ADDRESS<br><b>LONA CONING MD</b>   |   |   |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>June 12, 1967</b>     |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Kalbaugh Cem.</b>  |   |   | 23d. LOCATION (City, town or county) (State)<br><b>Elk Garden, W. Va.</b> |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>El Boal</b>  |  |   |   |   | ADDRESS<br><b>Westernport, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUN 12 1967</b>                        |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |  |  |  |  |  |

05808

05808

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

07503

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07479

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |   |   |  |   |  |  |   |
|--|---|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>ALLEGANY</b> MARYLAND  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |   |   |  | c. LENGTH OF STAY IN 1b<br><b>50 YEARS</b>  |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>DOA MEMORIAL HOSPITAL</b>   |   |   |  | e. STREET ADDRESS<br><b>535 N. CENTRE ST.</b>   |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>SLOAN</b> Middle <b>D.</b> Last <b>HOADLEY</b>   |   |   |  | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>23</b> Year <b>19 67</b>   |  |  |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JULY 13, 1894</b>             | 9. AGE (In years lost birthday)<br><b>72</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.                  |  | IF UNDER 24 HRS.<br>Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FREIGHT HANDLER</b>  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b> |   | 11. BIRTHPLACE (State or foreign country)<br><b>W. VA.</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |
| 13. FATHER'S NAME<br><b>DAVID HOADLEY</b>  |   |   |  | 14. MOTHER'S MAIDEN NAME<br><b>EMMA SAYLOR</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW 1</b>   |   | 16. SOCIAL SECURITY NO.<br><b>214 05 9213</b>   |  | 17. INFORMANT<br><b>MRS. FRANCES MYERS</b>  |  | Address<br><b>CUMBERLAND, MD.</b>                  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4201 CORONARY OCCLUSION</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>CORONARY SCLEROSIS</b><br>DUE TO (c)  |   |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>SUDDEN</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)   |   |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>   |   | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)               |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |   |  |   |  |  |   |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.   |   |   |  | 22. DATE SIGNED<br><b>JUNE 23, 1967</b>   |  |  |   |
| EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>  |   |   |  | CUMBERLAND, MD. (County)  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>JUNE 26, 1967</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FROSTBURG MEMORIAL PARK</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>FROSTBURG, MD.</b>  |  |  |   |
| 24. FUNERAL DIRECTOR<br><b>BYRON KIGHT</b>   |   |   |  | 25a. REC'D BY REGISTRAR<br><b>JUN 27 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |   |

1927

Benjamin Franklin

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07504

07480

|  |                                     |  |   |
|--|-------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Allegany</b>  |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Allegany</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rt#2 Cumberland</b>   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rt#2 Hazen Road Rural Cumberland</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Rt#2 Hazen Road Cumberland Md.</b>  |                                     | d. STREET ADDRESS<br><b>Box 808 Hazen Road</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Mary Amanda Horchler</b>  |                                     | 4. DATE OF DEATH<br>Month Day Year<br><b>June 10 19 67</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b> | 8. DATE OF BIRTH<br><b>Oct. 21, 1882</b>                              |
| 9. AGE (In years last birthday)<br><b>84</b> yrs.  |                                     | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Cumberland Md.</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Frederick Horchler (D)</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Almira Long (D)</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                                     | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>George W. Horchler</b>   |                                     | Address<br><b>Cumberland Md.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>4201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b><br>DUE TO (c)   |                                     |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                     |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>Hours</b>   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                     |  |   |
| ACTUAL SIGNATURE<br><b>Benedict Skitarelic</b>   |                                     | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type)<br><b>Benedict Skitarelic, M.D.</b>   |                                     | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                     | 22. DATE SIGNED<br><b>June 12, 1967</b>  |   |
| Address (Street, city, town, or county)<br><b>Cumberland, Md.</b>  |                                     |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>6/13/67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ss. Peter &amp; Paul Cem.</b>   | 23d. LOCATION (City, town or county) (State)<br><b>Cumberland Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Louis Stein Inc. Cumb. Md.</b>  |                                     | 25. REC'D BY REGISTRAR<br><b>JUN 15 1967</b>   |   |
| 26. REGISTRAR'S SIGNATURE<br><b>Charles J. Jugh</b>  |                                     |  |   |

12504

Albany

Albany

Albany

1115 Cumberland

1115 Haven Road Rural

1115 Haven Road Cumberland, Md.

Box 808 Haven Road

Male

Female

Horcher

June

Oct. 21, 1882

Female

Housewife

Cumberland, Md.

Frederick Horcher

George W. Horcher

Cumberland, Md.

Coroner's Office

Coroner's Office

Benedict Braterio, M.D.

June 12, 1907  
Cumberland, Md.

Burial

St. Peter's Paul

June 12, 1907

Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2 1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07505

CERTIFICATE OF DEATH

07481

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |   | c. LENGTH OF STAY IN 1b<br><b>3/31/1965</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Allegany County Infirmary</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>Kaplon</b> Last <b>Kaplon</b>   |   | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>22</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>10/1/1885</b>                                  |
| 9. AGE (In years last birthday)<br><b>81</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired: Office Mngr., Hersch Bros.</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Kouvne, Lithuania</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>U. S. A.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |
| 13. FATHER'S NAME<br><b>Abraham Kaplon</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Rebecca Arnstein</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>(If yes give war or dates of service)</b>  |   | 16. SOCIAL SECURITY NO.<br><b>214-05-5680</b>   |   |
| 17. INFORMANT<br><b>P.O. Box 599, Cumberland, Md. 21502</b>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocarditis</b><br>DUE TO <b>260 X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Gen Anteromedullary</b><br>DUE TO <b>Diabetes Mellitus</b><br>(c) <b>Diabetes Mellitus</b> |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   | INTERVAL BETWEEN ONSET AND DEATH  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/31/65</b> , 19__, to <b>6/22/67</b> , 19__, that (I) (we) last saw the deceased alive on <b>6/21/67</b> , 19__, and that death occurred at <b>5:10 A.M.</b> , from causes and on the date stated above. |   |   |   |
| 22a. SIGNATURE<br><b>George M. Simons</b>  |   | 22b. DATE SIGNED<br><b>6/22/1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>George M. Simons, M. D.</b>   |   | 22d. ADDRESS<br><b>Memorial Hospital, Cumberland, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>6/23/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>East View Cem.</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Md</b> |
| 24. FUNERAL DIRECTOR<br><b>Louis Stein Inc. Cumb. Md.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   | DATE <b>JUN 26 1967</b>   |   |

07502

Allegany

Allegany County Jail

Allegany County Jail

Robert

Robert

June

SS

87

Male

White

X

10/1/1988

31

Res: Res: Office Mgr., Harsh Bros., Harsh, Alabama

Allegany County Jail

Allegany County Jail

211-07-500 Allegany County Jail records

George N. Simpson, M.D.

Allegany County Jail

1  
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                               |   |  |   |                                  |  |  |  |
|--|--|-------------------------------|---|--|---|----------------------------------|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                               |   |  |   |                                  |  |  |  |
| 07506  |  |                               |   |  | CERTIFICATE OF DEATH  |                                  |  |  |  |
| 1. PLACE OF DEATH  |  |                               |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   |                                  |  |  |  |
| a. COUNTY <b>ALLEGANY</b>  |  |                               |   |  | a. STATE <b>MARYLAND</b>  |                                  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>   |  |                               |   |  | b. COUNTY <b>ALLEGANY</b>   |                                  |  |  |  |
| c. LENGTH OF STAY IN 1b <b>13 DAYS</b>   |  |                               |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>                              |                                  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>  |  |                               |   |  | d. STREET ADDRESS <b>1005 BEDFORD ST.</b>   |                                  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>EDWARD Simpkins</b>   |  |                               |   |  | 4. DATE OF DEATH <b>JUNE 18 1967</b>  |                                  |  |  |  |
| 5. SEX <b>MALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>10-19-04</b> |  | 9. AGE (In years last birthday) <b>62 yrs.</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATCHMAKER</b>  |  |                               |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>JEWELRY</b>  |                                  |  |  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND, ALLEGANY CTY.</b>   |  |                               |   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |                                  |  |  |  |
| 13. FATHER'S NAME <b>HARRY KELLER</b>  |  |                               |   |  | 14. MOTHER'S MAIDEN NAME <b>EMMA APPEL</b>  |                                  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |                               |   |  | 16. SOCIAL SECURITY NO. <b>214-05-5734</b>  |                                  |  |  |  |
| 17. INFORMANT <b>HOSPITAL RECORDS</b>  |  |                               |   |  | Address   |                                  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Pharynx with metastases</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                               |   |  |   |                                  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 HRS</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                               |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                    |                                  |  |  |  |
| 20c. TIME OF INJURY<br>Hour a.m. <b>19</b><br>p.m.   |  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>JUNE 5, 1967</b> to <b>JUNE 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>JUNE 18, 1967</b> , and that death occurred at <b>12</b> M, from the causes and on the date stated above.  |  |                               |   |  |   |                                  |  |  |  |
| 22a. SIGNATURE <b>DR. WYAND F. DOERNER, M.D.</b>   |  |                               |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                  | 22b. DATE SIGNED <b>6-19-67</b>  |  |  |
| 22c. PHYSICIAN'S NAME (Type)   |  |                               |   |  | 22d. ADDRESS <b>414 N. MECHANIC ST., CUMBERLAND, MD.</b>  |                                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |                               | 23b. DATE THEREOF <b>6/21/67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>  |                                  | 23d. LOCATION (City, town or county) (State) <b>Cumberland Allegany Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR <b>H. Lee Silcox</b>  |  |                               |   |  | ADDRESS <b>Cumberland, Maryland 21502</b>   |                                  | 25a. REC'D BY REGISTRAR <b>JUN 21 1967</b>                                       |  | 25b. REGISTRAR'S SIGNATURE                           |

07500

ALLEGANY

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ALLEGANY

CUMBERLAND

13 DAYS

CUMBERLAND

SACRED HEART HOSPITAL

1005 DEERD ST.

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JUNE

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WATCHMAKER

JEWELRY

MARYLAND, ALLEGANY CTY.

U.S.A.

HARRY KELLER

EMMY APPEL

HOSPITAL RECORDS

10-13-04

110

DR. WYAND F. DOERNER, M.D.

414 N. MECHANIC ST., CUMBERLAND, MD.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07507

## CERTIFICATE OF DEATH

07483

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |   | c. LENGTH OF STAY IN 1b<br><b>9/21/1966</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Allegany County Infirmary</b>  |   | d. STREET ADDRESS<br><b>406 Fayette St.</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>William Lawrence Keller</b>  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>June 29 19 67</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>5/12/1880</b>                                  |
| 9. AGE (In years last birthday)<br><b>87</b> yrs.   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dentist</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>West Virginia</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Henry Keller</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Zimmerman</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)<br><b>no</b>   |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>P.O. Box 599 Cumberland, Md.</b>  |   | <b>Allegany County Infirmary</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute clau-mechanical</b><br>5605 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bilateral Inguinal Hernias -</b><br>DUE TO (c) <b>Strangulated Inguinal Hernia, acute</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>approx. 3 hrs</b><br><b>Many years</b><br><b>acute</b><br><b>approx. 3 hrs</b> |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>B.P.H.: Bladder neck obstruction Smoker 15. Cholesterol</b>   |   |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9/21/1966</b> 19__, to <b>6/29/1967</b> 19__, that (I) (we) last saw the deceased alive on <b>6/29/1967</b> 19__, and that death occurred at <b>P.</b> M, from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><b>John A. Topper</b>   |   | 22b. DATE SIGNED<br><b>June 30, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John A. Topper, M.D.</b>   |   | 22d. ADDRESS<br><b>Memorial Hospital, Cumberland, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>7/3/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SS. Peter &amp; Paul Cem</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Md</b> |
| 24. FUNERAL DIRECTOR<br><b>Louis Stein Inc. Cumb. Md.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JUL 6 1967</b>  |   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10/1/50

STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                   |   |   |   |                                   |   |   |  |
|---|--|-----------------------------------|---|---|---|-----------------------------------|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                   |   |   |   |                                   |   |   |  |
| 07508   |  |                                   |   |   | 07484   |                                   |   |   |  |
| 1. PLACE OF DEATH   |  |                                   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)                 |                                   |   |   |  |
| a. COUNTY <b>ALLEGANY</b>   |  |                                   |   |   | a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>  |                                   |   |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |  |                                   |   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b> |                                   |   |   |  |
| c. LENGTH OF STAY IN 1b<br><b>22 HRS</b>  |  |                                   |   |   | d. STREET ADDRESS<br><b>8 WESTVIEW TERRACE</b>  |                                   |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>SACRED HEART HOSPITAL</b>  |  |                                   |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |                                   |   |   |  |
| 3. NAME OF DECEASED (Type or print)   |  |                                   |   |   | 4. DATE OF DEATH  |                                   |   |   |  |
| First <b>ESTELLA</b> Middle <b>E.</b> Last <b>KELLEY</b>  |  |                                   |   |   | Month <b>6-8-67</b> Day <b>19</b> Year <b>19</b>  |                                   |   |   |  |
| 5. SEX<br><b>F</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>  |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>4-4-10</b> |   | 9. AGE (In years last birthday)<br><b>57</b> yrs. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BEAUTICIAN</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>MILL CREEK, W.VA.</b>   |   |                                   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |  |
| 13. FATHER'S NAME<br><b>LORENZO A. MERRITT</b>  |  |                                   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>MARTHA SHRADER</b>   |                                   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>X</b>   |  |                                   |   |   | 16. SOCIAL SECURITY NO.<br><b>217-10-4333</b>   |                                   | 17. INFORMANT<br><b>HOSPITAL RECORD</b>   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE ANTERIOR MYOCARDIAL INFARCTION</b><br><b>4201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>DIABETES MELLITUS</b> |  |                                   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |                                   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                   |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)          |                                   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  |  |                                   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                |                                   | 20f. (City or town) (County) (State)  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov</b> , 19 <b>64</b> , to <b>6-8</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6-8</b> 19 <b>67</b> , and that death occurred at _____ M, from the causes and on the date stated above.   |  |                                   |   |   |   |                                   |   |   |  |
| 22a. SIGNATURE<br><i>Dr. M. Glick</i>   |  |                                   |   |   | 22b. DATE SIGNED<br><b>6-9-67</b>   |                                   |   |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>DR. M. GLICK</b>  |  |                                   |   |   | 22d. ADDRESS<br><b>126 N. SMALLWOOD ST., CUMB., MD. 21502</b>   |                                   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                                   | 23b. DATE THEREOF<br><b>6/10/67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>                                    |                                   | 23d. LOCATION (City, town or county) (State)<br><b>Cumberland Allegany Maryland</b> |   |  |
| 24. FUNERAL DIRECTOR<br><b>H. Lee Silcox Cumberland Maryland 21502</b>  |  |                                   |   |   | 25a. REC'D BY REGISTRAR<br><b>JUN 14 1967</b>   |                                   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                                  |   |  |

1937

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

22 MRS

CUMBERLAND

8 WESTVIEW TERRACE

SACRED HEART HOSPITAL

6-6-37

KELLEY

E.

ESTELLA

27

4-4-10

X

WHITE

F

USA

HILL CREEK, W.VA.

BEAUTY CLINIC

MARTHA SHRODER

LORENZO A. HERRITT

CUMBERLAND, MD.

HOSPITAL RECORD

217-10-4333

X

125 N. SMALLWOOD ST., CUMBERLAND, MD. 21502

DR. H. GLICK

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                     |   |   |   |   |  |   |  |
|--|--|-------------------------------------|---|---|---|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                     |   |   |   |   |  |   |  |
| 07509  |  |                                     |   |   | 07485   |   |  |   |  |
| 1. PLACE OF DEATH  |  |                                     |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)                 |   |  |   |  |
| a. COUNTY<br><b>ALLEGANY</b>   |  |                                     |   |   | a. STATE<br><b>MARYLAND</b>   |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |  |                                     |   |   | b. COUNTY<br><b>ALLEGANY</b>  |   |  |   |  |
| c. LENGTH OF STAY IN 1b<br><b>1 DAY</b>  |  |                                     |   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b> |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>SACRED HEART HOSPITAL</b>   |  |                                     |   |   | d. STREET ADDRESS<br><b>426 FURNACE ST.</b>   |   |  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                     |   |   |   |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>ANNA</b>   |  |                                     | First Middle Last<br><b>C. KIRBY</b>          |   |   | 4. DATE OF DEATH<br><b>JUNE 20 19 67</b>                                      |  |   |  |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>    |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>5-28-91</b>  |  | 9. AGE (In years last birthday)<br><b>76</b> yrs. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |                                     |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>CUMBERLAND, MD.</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>     |  |
| 13. FATHER'S NAME<br><b>JOHN M. RANK</b>   |  |                                     |   |   | 14. MOTHER'S MAIDEN NAME<br><b>ELIZABETH HOWELL</b>   |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |  |                                     | 16. SOCIAL SECURITY NO.<br><b>218-38-0408</b> |   | 17. INFORMANT<br><b>HOSPITAL RECORDS</b>  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY HEART DISEASE</b><br>4201<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>5 YEARS</b>  |  |                                     |   |   |   |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |                                     |   |   |   |   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5 - 6</b> , 19 <b>56</b> , to <b>6 - 20</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6 - 20</b> , 19 <b>67</b> , and that death occurred at <b>2 P.</b> from the causes and on the date stated above.   |  |                                     |   |   |   |   |  |   |  |
| 22a. SIGNATURE<br><b>Ralph W. Ballin</b>   |  |                                     |   |   | 22b. DATE SIGNED<br><b>6-20-67</b>  |   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>RALPH W. BALLIN, M.D.</b>   |  |                                     |   |   | 22d. ADDRESS<br><b>62 GREENE ST CUMBERLAND, MD. 21502</b>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE THEREOF<br><b>6/23/67</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Luke's Cem.</b>  |   | 23d. LOCATION (City, town or county) (State)<br><b>Cumberland MD.</b>         |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>STEIN'S FUNERAL HOME</b>  |  | ADDRESS<br><b>117 FREDERICK ST.</b> |   | 25a. REC'D BY REGISTRAR<br><b>JUN 23 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                            |  |   |  |

STEELE'S FUNERAL HOME

117 FREDERICK ST.

RALPH W. BALLIN, M.D.

25 GREENE ST CUMBERLAND, MD. 21202

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2 P

6 - 20

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6-20-67

X

X

CORONARY HEART DISEASE

2 YEARS

NO

218-38-0408

HOSPITAL RECORDS

JOHN M. RANK

ELIZABETH HOWELL

CUMBERLAND, MD.

U.S.A.

FEMALE

WHITE

X

2-28-91

28

ANN

C.

KIRBY

JUNE

20

67

SACRED HEART HOSPITAL

428 EUNICE ST.

1 DAY

CUMBERLAND

CUMBERLAND

ALLEGANY

MARYLAND

ALLEGANY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07510

CERTIFICATE OF DEATH

07486

|  |                                  |  |                                      |
|--|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>  |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>2/22/1967</b>  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Allegany County Infirmary</b>   |                                  | d. STREET ADDRESS<br><b>Hanekamp Street</b>  |                                      |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Galen C. Laird</b>  |                                  | 4. DATE OF DEATH Month Day Year<br><b>June 15, 1967</b>  |                                      |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>1/15/1901</b> |
| 9. AGE (In years last birthday) yrs.<br><b>66</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |                                      |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 11b. KIND OF BUSINESS OR INDUSTRY  |                                      |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Lonaconing, Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                      |
| 13. FATHER'S NAME<br><b>Clarkson Laird</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Mason</b>  |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.  |                                      |
| 17. INFORMANT<br><b>P.O. Box 599, Cumberland, Md.</b>  |                                  | <b>Allegany County Infirmary records.</b>  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial insufficiency.</b><br>DUE TO (b) <b>Chronic Emphysema.</b><br>DUE TO (c) <b>Hypertensive C.V. D.</b>                  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Approx. 15 yrs.</b>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)<br><b>Chronic Myocardial Insufficiency.</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>2/22/1967</b> , 19____, to <b>6/15/1967</b> , that (I) (we) last saw the deceased alive on <b>6/14/1967</b> 19____, and that death occurred at <b>A.</b> M, from causes and on the date stated above. |                                  |  |                                      |
| 22a. SIGNATURE<br><b>John A. Topper</b>  |                                  | at <b>8:55 A. M. D.S.T.</b><br>MED. ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED<br><b>6/15/1967</b> |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John A. Topper, M. D.</b>   |                                  | 22d. ADDRESS<br><b>Memorial Hospital, or home, Hyndman, Pennsylvania</b>   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>6/18/1967 Burial</b>   |                                  | 23b. DATE THEREOF<br><b>Burial</b>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Frostburg, Md.</b>   |                                      |
| 24. FUNERAL DIRECTOR<br><b>George Eichhorn</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JUN 16 1967</b>  |                                      |
| ADDRESS<br><b>Lonaconing, Md.</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                      |

07310

Allegany

Charleston

Allegany County, Maryland

Garret

U. S.

Latrod

June 15,

07

White

Male

1/15/1901

60

Lawsoning, Maryland

U. S. A.

Charleston, Md.

Henry Person

Allegany County, Maryland, Md.  
U. S. A. Box 700, Charleston, Md.  
Allegany County, Maryland, Md.

*Not a member of the  
the organization*

*Hyman, G. I. B.*

*Not a member of the  
the organization*

07310

07310

07310

*John A. Tabor*

John A. Tabor, M. D.

Charleston

Charleston

Charleston

George Washington, Md.

at 6:30 A. M. 6/15/1901

Memorial Hospital, or  
Hennrich, Pennsylvania

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07511

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07487

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |   | c. LENGTH OF STAY IN 1b<br><b>DOA</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Memorial Hospital</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Mary Jane Lepley</b>   |   | 4. DATE OF DEATH<br><b>June 8, 1967</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>May 13, 1909</b>   |
| 9. AGE (In years last birthday) yrs.<br><b>58</b>  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   | 12. KIND OF BUSINESS OR INDUSTRY  |   |
| 13. BIRTHPLACE (State or foreign country)<br><b>Fairhope, PA. RD#1</b>   |   | 14. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 15. FATHER'S NAME<br><b>Oliver Emerick</b>   |   | 16. MOTHER'S MAIDEN NAME<br><b>Minnie Rebecca Clites</b>  |   |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |   | 18. SOCIAL SECURITY NO.<br><b>217-14-4210</b>   |   |
| 19. INFORMANT<br><b>Louis Lepley, Corriganville, Md.</b>   |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>Coronary Sclerosis</b><br>DUE TO<br>(c)   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Diabetes Mellitus</b>   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not While of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |   |   |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.<br>EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 7, 1967</b><br>Address (Street, city, town, or county) <b>Cumberland, Md.</b> |   |
| 22. DATE SIGNED  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>June 11, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Comps Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Hyndman Somerset Co., Pa.</b> |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Leigler</b>   |   | ADDRESS<br><b>Hyndman, Pa.</b>  |   |
| 25a. REC'D. BY REGISTRAR<br><b>JUN 14 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. ...</b>   |   |

1000

1000



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07512

CERTIFICATE OF DEATH

07488

|  |                                  |   |  |
|--|----------------------------------|---|--|
| f. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Westernport</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Westernport</b>  |  |
| c. LENGTH OF STAY IN fb<br><b>60 yrs.</b>  |                                  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>105 First Street.</b>   |                                  | d. STREET ADDRESS<br><b>105 First Street.</b>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Norman</b> Middle <b>Gilbert</b> Last <b>Linkswiler</b>  |                                  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>17</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 5, 1907</b> |
| 9. AGE (In years lost birthday) yrs.<br><b>60</b>  |                                  | IF UNDER 1 YEAR<br>Months <b>01</b> Days <b>11</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Miner</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Coal</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Westernport, Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>James D. Linkswiler</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Maggie Mae Reeves</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>216-07-9635</b>   |  |
| 17. INFORMANT<br><b>Mrs. Norman Linkswiler, 105 First St.</b>  |                                  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Silicosis</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Silicosis</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>9</b> p.m. <b>17</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 10, 1963</b> , to <b>June 17, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 17, 1967</b> , and that death occurred at <b>9:20 PM</b> , from causes and on the date stated above.   |                                  |   |  |
| 22a. SIGNATURE<br><b>Paul R. Wilson</b>  |                                  | 22b. DATE SIGNED<br><b>June 19, 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Paul R. Wilson M.D.</b>   |                                  | 22d. ADDRESS<br><b>Piedmont, W. Va.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>June 20, 1967</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Philos Cemetery</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Westernport, Allegany, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>E.S. Boal</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JUN 20 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07512

DATE OF BIRTH

UNITED STATES DEPARTMENT OF JUSTICE

NAME

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX

DATE OF BIRTH

PLACE OF BIRTH

CITY

STATE

COUNTRY

DATE OF DEATH

PLACE OF DEATH

CITY

STATE

COUNTRY

DATE OF INTERVIEW

INTERVIEWER

REMARKS

REMARKS

1961 08 18 1961

1961 08 18 1961

1961 08 18 1961

1961 08 18 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07513

CERTIFICATE OF DEATH

07489

|   |                                  |   |                                     |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Midland</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>Midland</b>   |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |                                  | d. STREET ADDRESS   |                                     |
| 3. NAME OF DECEASED<br>(Type or print) <b>Salem</b>   |                                  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>16</b> Year <b>1967</b>  |                                     |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/2/1900</b> |
| 9. AGE (In years last birthday) <b>67</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <b>00</b> Ooys <b>00</b> Hours <b>00</b> Min. <b>00</b>   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Miner</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Coal Mine</b>   |                                     |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Vale Summitt, Md</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                     |
| 13. FATHER'S NAME<br><b>Noah Loar</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Violet Morton</b>  |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>yes W. WAR 1</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>214-01-6661</b>   |                                     |
| 17. INFORMANT<br><b>Mrs. Viola Loar</b>   |                                  | Address<br><b>Midland, Md.</b>  |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br>DUE TO (b) <b>Coronary Insufficiency</b><br>DUE TO (c) <b>Atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 years</b><br><b>years</b>  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Ooys, Year<br>Hour o.m. <b>19</b> p.m.   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work  |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 8, 1967</b> to <b>June 16, 1967</b> that (I) (we) last saw the deceased alive on <b>June 8, 1967</b> , and that death occurred at <b>6:16</b> M, from causes and on the date stated above.  |                                  |   |                                     |
| 22a. SIGNATURE<br><b>L. R. MILES, JR</b>  |                                  | 22b. DATE SIGNED<br><b>6.16.67</b>  |                                     |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. R. MILES, JR</b>  |                                  | 22d. ADDRESS<br><b>LONA CONING MD.</b>  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>6/19/1967</b>   |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Frostburg Memorial Park Frostburg</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>A. Md</b>   |                                     |
| 24. FUNERAL DIRECTOR<br><b>George Eichhorn</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>JUN 19 1967</b>   |                                     |
| ADDRESS<br><b>Lonaconing, Md.</b>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                     |

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to 07 June 1907

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07514

CERTIFICATE OF DEATH

07490

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FROSTBURG</b>   |  | c. LENGTH OF STAY IN 1b<br><b>2 WEEKS</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FROSTBURG</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MINERS HOSPITAL</b>   |  |   |  | d. STREET ADDRESS<br><b>224 EAST MAIN STREET</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>RUTH BEATRICE LOCKARD</b>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>JUNE 26, 1967</b>  |  |   |  |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>JUNE 6, 1907</b>   |  |
| 9. AGE (In years last birthday)<br><b>60</b> yrs.  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>ALLEGANY, MARYLAND</b>                  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  | 13. FATHER'S NAME<br><b>HENRY STEELE</b>  |  |   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>DAISY MUSETTER</b>  |  |   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |  |   |  |
| 16. SOCIAL SECURITY NO.  |  |   |  | 17. INFORMANT<br><b>FROSTBURG, MD.<br/>MR. GEORGE LOCKARD, 224 E. MAIN STREET</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic glomerular nephritis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular disease</b><br>DUE TO (c) <b>Chronic chest disease</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>months</b><br><b>years</b><br><b>years</b> |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>       |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>67</b> to <b>June 26</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>June 26</b> , 19 <b>67</b> , and that death occurred at <b>12:30</b> P.M. from causes and on the date stated above.   |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>John B. Davis, M.D.</b>   |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22b. DATE SIGNED<br><b>6/27/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JOHN B. DAVIS, M.D.</b>   |  |   |  | 22d. ADDRESS<br><b>2 BROADWAY, FROSTBURG, MARYLAND</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>JUNE 29, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FROSTBURG MEM. PARK</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>FROSTBURG, MARYLAND</b>                       |  |
| 24. FUNERAL DIRECTOR<br><b>MARILOU M. SOWERS</b>   |  |   |  | 25. RECORD BY REGISTRAR<br><b>JUL 6 1967</b>  |  |   |  |
| 26. REGISTRAR'S SIGNATURE<br><b>John B. Davis</b>  |  |   |  | 27. REGISTRAR'S SIGNATURE<br><b>John B. Davis</b>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                  |   |   |  |   |  |   |  |
|--|--|----------------------------------|---|---|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                  |   |   |  |   |  |   |  |
| 07515  |  |                                  |   |   | CERTIFICATE OF DEATH   |   |  |   |  |
| 07491  |  |                                  |   |   |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> <b>ALLEGANY</b><br>b. COUNTY <b>ALLEGANY</b> |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>CORRIGANVILLE</b>   |  |                                  |   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>CORRIGANVILLE</b>   |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>SACRED HEART HOSPITAL</b>   |  |                                  |   |   | d. STREET ADDRESS<br><b>BOX 173, Park Ave.</b>   |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>GUY</b> Middle <b>Earl</b> Last <b>MARTIN</b>  |  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>19</b> Year <b>1967</b>   |   |  |   |  |
| 5. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>4-22-39</b>  |  | 9. AGE (In years last birthday)<br><b>28</b> yrs. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Custodian,</b>   |  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Fraternal Organiztn.</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>ALLEGANY CTY., MARYLAND</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>     |  |
| 13. FATHER'S NAME<br><b>GUY MARTIN</b>   |  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Esther Dickel</b>   |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |  |                                  |   |   | 16. SOCIAL SECURITY NO.<br><b>212-38-6538</b>  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b><br><b>1963</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Ewing's Sarcoma - R. ribs</b><br>DUE TO<br>(c) |  |                                  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>18 mos</b>  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                                  |   |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>8 Jan.</b> , 1967, to <b>19 June</b> , 1967, that (I) (we) last saw the deceased alive on <b>18 June</b> 1967, and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above.  |  |                                  |   |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>James Stegmaier</b>   |  |                                  |   |   | 22b. DATE SIGNED<br><b>19 June 67</b>  |   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR. JAMES G. STEGMAIER</b>  |  |                                  |   |   | 22d. ADDRESS<br><b>122 S. CENTRE STREET, CUMBERLAND, MD</b>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                                  | 23b. DATE THEREOF<br><b>6/21/67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Restlawn Mem. Gardens</b>   |   | 23d. LOCATION (City, town or county) (State)<br><b>Cumberland, Allegany, Md.</b> |   |  |
| 24. FUNERAL DIRECTOR<br><b>H. Wayne George Cumberland, Maryland</b>  |  |                                  |   |   | 25a. REC'D BY REGISTRAR<br><b>JUN 23 1967</b>  |   |  |   |  |
|  |  |                                  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |  |   |  |

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212-37-6238 HOSPITAL RECORDS



DR. JAMES C. STEENHILFER

123 S. CENTRE STREET, COMBELLAND, WA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07516

CERTIFICATE OF DEATH

07492

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|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg</b>  |  | c. LENGTH OF STAY IN 1b<br><b>21/1</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Miners Hospital</b>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HAZEL</b> Middle <b>MATTHEWS</b> Last   |  | 4. DATE OF DEATH <b>6/17/1967</b> Month Day Year   |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>6/8/1908</b> 9. AGE (In years last birthday) <b>59</b> yrs.                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>West Virginia</b>                    |
| 13. FATHER'S NAME<br><b>Louis Smith</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Rose Bradford</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |
| 17. INFORMANT Address<br><b>Edward P. Matthews, Moscow, MD. (Husband)</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CORONARY SCLEROSIS</b> DUE TO<br>(c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 hours</b><br><b>10 YRS.</b>                           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>JUNE 16, 1967</b> , to <b>JUNE 17, 1967</b> , that (I) (we) last saw the deceased alive on <b>JUNE 17, 1967</b> , and that death occurred at <b>2:55AM</b> , from causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE<br><b>G. Paige Strong</b>  |  | 22b. DATE SIGNED<br><b>June 17, 1967</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>A. Paige Strong</b>  |  | 22d. ADDRESS<br><b>167 E. MAIN ST - FROSTBURG, MD.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>6/19/1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Laruel Hill Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Moscow, Md.</b>                            |
| 24. FUNERAL DIRECTOR<br><b>George Eichhorn</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUN 20 1967</b>  |  |
| ADDRESS<br><b>Lonaconing, Md.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>  |  |

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RECORD OF DEATH

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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07517

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07493

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>418 Oldtown Road</b>  |  |   |  | d. STREET ADDRESS<br><b>418 Oldtown Road</b>   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Elizabeth Gillin McCartneysmith</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>25</b> Year <b>19 67</b>  |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>June 16, 1891</b>   |  |
| 9. AGE (In years lost birthday)<br><b>76</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. |  | 11. BIRTHPLACE (State or foreign country)<br><b>Waterloo, Iowa</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Franklin H. McCartney</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Frances J. Gillin</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>Eugene Abe, 502 Montreal Avenue, Cumb., Md.</b>  |  |  |  |
| 17. INFORMANT<br><b>Eugene Abe, 502 Montreal Avenue, Cumb., Md.</b>  |  |   |  | Address  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4201</b><br>DUE TO <b>CORONARY OCCLUSION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>CORONARY SCLEROSIS</b><br>(b) <b>---</b><br>(c) <b>---</b>   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>SUDDEN</b>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                 |  |
| 20f. (City or town) (County) (State)   |  |   |  | 20g. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.<br>EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 25, 1967</b><br>Address (Street, city, town, or county) <b>Cumberland, Md.</b> |  |  |  |
| 22. DATE SIGNED  |  |   |  | 23. DATE SIGNED  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>June 28, 1967</b>                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Davis Memorial Park</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Near Cumberland, Allegany, Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Hafer, Jr.</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>John J. Hafer, Jr.</b>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Hafer, Jr.</b>  |  |   |  | 25c. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |  |

5250

11250

0001-0001-0001

of K&S, Inc.

Concord, N.H.

1. *Phragmites australis* (Cav.) Trin. ex Steud.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and retain an event within 72 hours after death.

99

1

2

BR

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |   |  |   |  |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY   |  | ALLEGANY   |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE |  | MARYLAND  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  | FROSTBURG  |  | c. LENGTH OF STAY IN 1b   |  | D O A   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)                  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |  | MINERS HOSPITAL  |  | d. STREET ADDRESS   |  | RT. 2   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)   |  | First<br>MARTHA  |  | Middle<br>ELLEN   |  | Last<br>McKENZIE  |  | 4. DATE OF DEATH<br>Month<br>JUNE<br>Day<br>8,<br>Year<br>19 67                                   |  |
| 5. SEX<br>FEMALE   |  | 6. COLOR OR RACE<br>WHITE  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>FEB. 24, 1904   |  | 9. AGE (In years last birthday)<br>63 yrs.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | HOUSE WORK   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>PRIVATE HOMES  |  | 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 13. FATHER'S NAME<br>GEORGE CATON  |  |  |  | 14. MOTHER'S MAIDEN NAME<br>NANCY ALBRIGHT  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO.<br>216-22-5441   |  | 17. INFORMANT<br>CLARENCE McKENZIE, RT. 2, BOX 462, FROSTBURG, MD.  |  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>4301<br>DUE TO<br>CORONARY OCCLUSION<br>CORONARY SCLEROSIS<br>DUE TO<br>DUE TO |  |  |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>Sudden  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |  |  |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)   |  | 20g. (County)   |  |
| 20h. (State)   |  | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>Benedict Skitarelic  |  | EXAMINER'S NAME (Type)<br>BENEDICT SKITARELIC, M. D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                       |  |
| 22. DATE SIGNED<br>6/9/67  |  | Address (Street, city, town, or county)<br>RD 9, CUMBERLAND, MD  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  | 23b. DATE THEREOF<br>JUNE 12 '67   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>JOHNSON CEMETERY  |  | 23d. LOCATION (City, town or county) (State)<br>GARRETT COUNTY, MARYLAND                          |  |   |  |
| 24. FUNERAL DIRECTOR<br>JOSEPH R. DURST, SR., FROSTBURG, MD.   |  |  |  | 25a. REC'D BY REGISTRAR<br>JUN 14 1967  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |   |  |

1351A

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10/1/83 BY SP-6  
[illegible]

100-100000-100000

100-100000-100000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                     |  |   |  |   |  |   |  |  |  |   |  |
|--|--|-------------------------------------|--|---|--|---|--|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                     |  |   |  |   |  |   |  |  |  |   |  |
| 07519 Item #12 Film #4390 5/23/67 pc   |  |                                     |  |   |  |   |  |   |  |  |  |   |  |
| 07495  |  |                                     |  |   |  |   |  |   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |  |                                     |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |  |   |  |  |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |  |                                     |  |   |  | c. LENGTH OF STAY IN 1b<br><b>15 DAYS</b>   |  |   |  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>SACRED HEART HOSPITAL</b>   |  |                                     |  |   |  | d. STREET ADDRESS<br><b>406½ FURNACE ST., CUMB., MD.</b>  |  |   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>PETER</b> Middle <b>C.</b> Last <b>MECONI</b>  |  |                                     |  |   |  | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>14</b> Year <b>19 67</b>   |  |   |  |  |  |   |  |
| 5. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>    |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>4-14-1900</b>  |  | 9. AGE (In years last birthday)<br><b>67</b> yrs.                           |  | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>14</b> Hours <b>19</b> Min. <b>67</b> |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>STORE OWNER</b>  |  |                                     |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>LUCCA, ITALY</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>ANASTASIA</b>  |  |                                     |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>FRANCESCA</b>  |  |   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>YES</b>  |  |                                     |  | 16. SOCIAL SECURITY NO.<br><b>214-32-2909</b>   |  | 17. INFORMANT<br><b>HOSPITAL RECORD</b> Address   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIC POISONING</b><br><b>296X</b> DUE TO <b>GASTROINTESTINAL HEMMORHAGE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SEVERE ANEMIA WITH THROMBOCYTOPENIA</b><br>(c) <b>CHRONIC LIVER DISEASE-ARTERIOSCLEROTIC HEART DISEASE</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>CHRONIC LIVER DISEASE-ARTERIOSCLEROTIC HEART DISEASE</b> |  |                                     |  |   |  |   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 WKS</b><br><b>4 WKS.</b> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                     |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)<br><b>NONE</b>   |  |   |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>   |  |                                     |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)<br><b>MAY 30, 19 67 JUNE 14, 19 67</b> |  |  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>JUNE 14, 19 67</b> to <b>JUNE 14, 19 67</b> , that (I) (we) last saw the deceased alive on <b>JUNE 14, 19 67</b> , and that death occurred at <b>5:05 AM</b> , from the causes and on the date stated above.  |  |                                     |  |   |  |   |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><i>James P. Hallinan M.D.</i>  |  |                                     |  |   |  | ATTENDING PHYS. # <b>6</b> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                      |  | 22b. DATE SIGNED<br><b>6-14-67</b>  |  |  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JAMES P. HALLINAN, M.D.</b>   |  |                                     |  |   |  | 22d. ADDRESS<br><b>140 BEDFORD ST., CUMB., MD. 21502</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE THEREOF<br><b>6/16/67</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cem.</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Cumberland MD</b>  |  |   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>James Stein Inc. - Cumb. MD</i>   |  |                                     |  |   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br><b>JUN 19 1967</b>                               |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                                   |  |   |  |

JAMES P. HALLINAN, M.D.

140 BEDFORD ST., CUMM., MD. 21202

JUNE 14, 67

67

MAY 30, 67

2:02 PM

JUNE 14, 67

67

6-14-67

NOTE

CHRONIC LIVER DISEASE-ARTERIOSCLEROTIC HEART DISEASE

SEVERE ANEMIA WITH THROMBOCYTOPENIA

GASTROINTESTINAL HEMORRHAGE

UREMIC POISONING

21+32-2009 HOSPITAL RECORD

ANASTASIA

FRANCESA

STORE OWNER

LUGCA, ITALY

MALE WHITE

4-14-1900

X

PETER

C.

MECHANI

JUNE 14

67

SACRED HEART HOSPITAL

400 1/2 FURNACE ST., CUMM., MD.

CUTLERLAND

12 DAYS

CUMBERLAND

ALLESMY

MARYLAND

ALLESMY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07520

CERTIFICATE OF DEATH

07496

|   |                           |   |   |
|---|---------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Allegany</u> b. COUNTY <u>Md</u>                       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Frostburg</u>  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Mt. Savage</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Miner's Hospital</u>   |                           | d. STREET ADDRESS<br><u>01.1</u>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Cora Belle Metz</u>   |                           | 4. DATE OF DEATH<br>Month <u>June</u> Day <u>16</u> Year <u>19 67</u>   |   |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Aug. 9, 1890</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs.  |                           | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Swanton, Md.</u>  |                           | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Benjamin Sweitzer</u>   |                           | 14. MOTHER'S MAIDEN NAME<br><u>Isabelle Schroyer</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                           | 16. SOCIAL SECURITY NO.<br><u>---</u>   |   |
| 17. INFORMANT<br><u>Howard Metz, Mt. Savage, Md.</u>  |                           | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>due to coronary sclerosis</u><br>DUE TO<br>(c) <u>Hypertensive cardiovascular disease</u> |                           | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 days</u><br><u>10 years</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Diabetes mellitus</u>  |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 12, 19 67</u> , to <u>June 16, 19 67</u> , that (I) (we) last saw the deceased alive on <u>June 15, 19 67</u> , and that death occurred at <u>3:15 AM</u> , from causes and on the date stated above.   |                           |   |   |
| 22a. SIGNATURE<br><u>G. Paige Strong</u>  |                           | 22b. DATE SIGNED<br><u>June 16, 1967</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)  |                           | 22d. ADDRESS  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                           | 23b. DATE THEREOF<br><u>6/20/67</u>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>New Germany M.E. Cem.</u>  |                           | 23d. LOCATION (City or Town) (County) (State)<br><u>Grantsville, Garrett, Md.</u>   |   |
| 24. FUNERAL DIRECTOR<br><u>Ruth Newman</u>  |                           | 25a. REC'D BY REGISTRAR<br><u>JUN 21 1967</u>   |   |
| ADDRESS<br><u>Grantsville, Md.</u>  |                           | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |

05220

CENTRAL AT CLARK

3118

Unit's operational information

due to command release

Hydrogen central observation 10 days

Diatomic molecule

June 12 03 June 14 10  
A71A

June 12 03

June 14 10

X

Air Force Group

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07521

CERTIFICATE OF DEATH

07497

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>ALLEGANY</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |   | c. LENGTH OF STAY IN 1b<br><b>2 HRS.</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>   |   | d. STREET ADDRESS<br><b>13 LAING AVENUE</b>   |  |
| 3. NAME OF DECEASED (Type of print)<br>First <b>BABY BOY</b> Middle <b>MILLER</b> Last <b>MILLER</b>   |   | 4. DATE OF DEATH<br>Month <b>6-5-</b> Day <b>19</b> Year <b>67</b>  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-5-67</b>  |
| 9. AGE (In years lost birthday) yrs.<br><b>2.3</b>   |   | 10. IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>3</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>CUMBERLAND, MD.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>EUGENE MILLER</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>LOIS J. CHANEY</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |   | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |  |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL</b>  |   | Address<br><b>CUMBERLAND, MD.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ANOXIA</b><br><b>7625</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PREMATUREITY</b><br>DUE TO (c) |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>19</b> , to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred <b>9:30AM</b> , from causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><b>Robert D. Brodell</b>   |   | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR. DELANO RAYSON</b>   |   | 22d. ADDRESS<br><b>CUMBERLAND, MD.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>JUNE 6, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PLEASANT VALLEY</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>LOCKLYNN, MD-GARRETT</b>           |
| 24. FUNERAL DIRECTOR<br><b>JAMES FRANCIS SCARPELLI, CUMBERLAND, MD.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JUN 9 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                     |

7-274753

STATE DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
BUREAU OF VITAL STATISTICS  
JANUARY 1917

01224

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND, MD.

2 Mrs.

CUMBERLAND

13 FAIRING AVENUE

67

6-2-2

MILLER

BABY BOY

6-2-2

WHITE

MALE

LOIS J. CHANEY

EUGENE MILLER

MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. KOKKONEN  
JANUARY 1917

CUMBERLAND, MD.

1917

**FOR STATE  
HEALTH DEPT**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

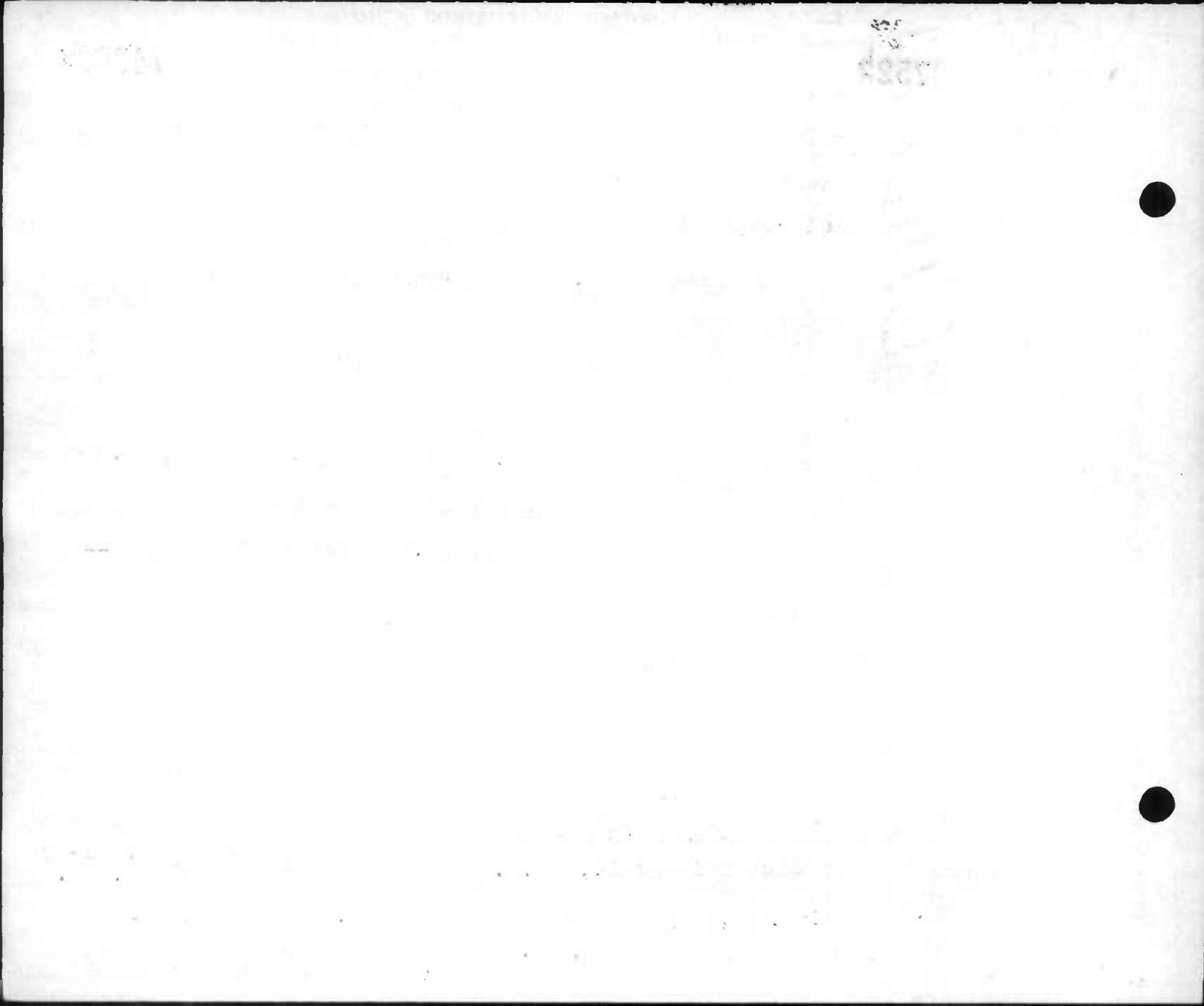
07522

**MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07498

|  |  |  |                                       |   |   |   |  |
|--|--|--|---------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |  |  |                                       | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>   |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |  |  | c. LENGTH OF STAY IN 1b<br><b>DOA</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b> |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Memorial Hospital</b>   |  |  |                                       | d. STREET ADDRESS<br><b>Polk Street</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Frances</b> Middle <b>S.</b> Last <b>Mongold</b>   |  |  |                                       | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>8</b> Year <b>1967</b>   |   |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |                                       | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |   | 8. DATE OF BIRTH<br><b>June 6, 1906</b>   |  |
| 9. AGE (In years last birthday) yrs.<br><b>61</b>  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |                                       | 11. BIRTHPLACE (State or foreign country)<br><b>Hartford, Conn</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Waitress</b>   |  |  |                                       | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Hartford, Conn</b>                                |  |
| 13. FATHER'S NAME<br><b>?</b>  |  |  |                                       | 14. MOTHER'S MAIDEN NAME<br><b>?</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>yes War II</b>   |  |  |                                       | 16. SOCIAL SECURITY NO.   |   |   |  |
| 17. INFORMANT<br><b>Mr. Cleo Mongold, Cumberland, Md. Husband</b>  |  |  |                                       | Address   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>4201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary Sclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |  |                                       |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>--</b> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>       |  |  |                                       |   |   |   |  |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.<br>EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>  |  |  |                                       | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 8, 1967</b><br>Address (Street, city, town, or county) <b>Cumberland, Md.</b> |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>June 13, 1967</b>  |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Winchester National Cem, Winchester, Va.</b>   |   | 23d. LOCATION (City or Town) (County) (State)   |  |
| 24. FUNERAL DIRECTOR<br><b>James F. Scarpelli, Cumberland, Md.</b>   |  |  |                                       | 25. RECEIVED BY REGISTRAR<br><b>June 14 1967</b><br>DATE  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles J. J...</i>  |  |

MEDICAL CERTIFICATION



13  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07523

CERTIFICATE OF DEATH

07499

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>5 DAYS</b>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                  | d. STREET ADDRESS<br><b>121 PENNSYLVANIA AVE.</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>E.</b> Last <b>MORRIS</b>   |                                  | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>4</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>1905</b><br><b>8-10-1905</b> |
| 9. AGE (In years lost birthday)<br><b>61</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>1</b> Hours <b>1</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Textile &amp; Cab Co.</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>HYNDMAN, PA.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>JOHN MORRIS</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>MARTHA DEVORE</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4500</b><br>DUE TO <b>Coronary heart failure</b><br>(b) <b>Atherosclerosis</b><br>DUE TO <b>Arteriosclerosis</b><br>(c) <b>Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1905</b> , to <b>6/4/1967</b> , that (I) (we) last saw the deceased alive on <b>6/4/1967</b> , and that death occurred at <b>7:05 P.M.</b> causes and on the date stated above.   |                                  |   |  |
| 22a. SIGNATURE<br><b>Dr. Weisman</b>   |                                  | 22b. DATE SIGNED<br><b>6/5/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR. WEISMAN</b>   |                                  | 22d. ADDRESS<br><b>59 GREENE STREET, CUMBERLAND, MD.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>June 7, 1967</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Patrick's Cemetery</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Md. Allegany</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>James F. Scarpelli, Cumberland, Md.</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JUN 9 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                  |   |  |

07287

INTERVIEW OF 2-1-58

04493

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

2 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

151 PENNSYLVANIA AVE.

JOHN

THORNTON

JUNE

07

WHITE

6-12-1902

61

RETIRED

HYNDEN, PA.

USA

JOHN THORNTON

MARTHA BEVORE

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. WEISMAN

2. INTERVIEW, CUMBERLAND, MD.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07524

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07500

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Ma.</u> b. COUNTY <u>Allegany</u>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Corriganville</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>Most of Life</u>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Corriganville, Md.</u>  |                                  | d. STREET ADDRESS<br><u>Rt. 1 Hyndman, Pa.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Rt. 1 Hyndman</u>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Sylvia</u> Middle <u>A.</u> Last <u>Myers</u>   |                                  | 4. DATE OF DEATH<br>Month <u>June</u> Day <u>16</u> Year <u>19 67</u>   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>Oct. 16, 1907</u> |
| 9. AGE (In years<br>at birth)<br><u>59</u> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <u>5</u> Days <u>19</u> Hours <u>67</u> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Pa.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Peter Bowman</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Alice (Bird)</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  |
| 17. INFORMANT<br><u>Gordon Bowman</u>  |                                  | Address<br><u>R. D. #2 Glen Rock, Pa.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><u>4201</u> IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY SCLEROSIS</u><br>DUE TO (c)  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>SUDDEN</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>19</u> o.m. p.m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |  |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u><br>EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>   |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>June 16, 1967</u><br>Address (Street, city, town, or county) <u>Cumberland, Maryland</u> |  |
| 22. DATE SIGNED  |                                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>Jun. 18, 1967</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Savage Meth. Cemetery</u>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><u>Mt. Savage Allegany Md.</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>William G. Kight</u>  |                                  | 25. JUDICIAL REGISTRAR<br><u>June 20 1967</u>   |  |
| ADDRESS<br><u>Cumberland, Md.</u>  |                                  | DATE<br><u>June 20 1967</u>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07525

CERTIFICATE OF DEATH

07501

|  |                                  |   |                                       |
|--|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>Lonaconing</b>  |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Miners Hospital</b>   |                                  | d. STREET ADDRESS<br><b>Dudley Street</b>   |                                       |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>JESSIE</b> Middle <b>S.</b> Last <b>NEAT</b>  |                                  | 4. DATE OF DEATH<br>Month <b>6</b> Day <b>14</b> Year <b>1967</b>   |                                       |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/27/1893</b> |
| 9. AGE (In years last birthday)<br><b>73</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   |                                       |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 12. BIRTHPLACE (County & State, or foreign country)<br><b>Lonaconing, Md.</b>   |                                       |
| 13. FATHER'S NAME<br><b>John F. Steele</b>   |                                  | 14. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                       |
| 15. FATHER'S MAIDEN NAME<br><b>Frances Emerson</b>   |                                  | 16. MOTHER'S MAIDEN NAME<br><b>Irvin Neat</b>   |                                       |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 18. SOCIAL SECURITY NO.<br><b>None</b>  |                                       |
| 19. INFORMANT<br><b>Irvin Neat</b>   |                                  | 20. ADDRESS<br><b>Lonaconing, Md.</b>   |                                       |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b><br>DUE TO <b>Coronary Insufficiency</b><br>DUE TO <b>Atherosclerosis generalized</b>               |                                  | 22. INTERVAL BETWEEN ONSET AND DEATH<br><b>(30N)</b>  |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)<br><b>Diabetes mellitus</b>  |                                  | 23. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                       |
| 24. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 25. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 26. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>19</b> p.m.  |                                  | 27. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work   |                                       |
| 28. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 29. (City or town) (County) (State)   |                                       |
| 30. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>June 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 14, 1967</b> , and that death occurred at <b>9 P</b> M, from causes and on the date stated above. |                                  |   |                                       |
| 31. SIGNATURE<br><b>LR Miles Jr</b>  |                                  | 32. DATE SIGNED<br><b>6.15.67</b>   |                                       |
| 33. PHYSICIAN'S NAME (Type)<br><b>LR MILES JR MD.</b>  |                                  | 34. ADDRESS<br><b>LONA CONING MD</b>  |                                       |
| 35. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 36. DATE THEREOF<br><b>6/17/1967</b>  |                                       |
| 37. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park</b>  |                                  | 38. LOCATION (City or Town) (County) (State)<br><b>Frostburg, Md.</b>   |                                       |
| 39. FUNERAL DIRECTOR<br><b>George Eichhorn</b>   |                                  | 40. ADDRESS<br><b>Lonaconing, Md.</b>   |                                       |
| 41. REC'D BY REGISTRAR<br><b>JUN 16 1967</b>   |                                  | 42. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                       |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                  |                                    |   |   |  |                      |   |   |  |  |
|--|--|----------------------------------|------------------------------------|---|---|--|----------------------|---|---|--|--|
| 07526 CERTIFICATE OF DEATH 07502   |  |                                  |                                    |   |   |  |                      |   |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |  |                                  |                                    |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |  |                      |   |   |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |  |                                  |                                    |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>                                       |  |                      |   |   |  |  |
| c. LENGTH OF STAY IN 1b<br><b>2 YEARS</b>  |  |                                  |                                    |   | d. STREET ADDRESS<br><b>200 SETON DRIVE</b>   |  |                      |   |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>SACRED HEART HOSPITAL</b>   |  |                                  |                                    |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                      |   |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)   |  |                                  | First <b>FAYE</b>                  |   | Middle <b>E.</b>  |  | Last <b>OLMSTEAD</b> |   | 4. DATE OF DEATH<br>Month <b>6</b> Day <b>2</b> Year <b>19 67</b> |  |  |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b> |                                    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>03-24-95</b>  |                      | 9. AGE (In years last birthday)<br><b>72</b> yrs.                     |   | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |  |                                  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>VINLAND, KANSAS</b>  |                      |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                     |  |  |
| 13. FATHER'S NAME<br><b>CHARLES W. WILLIAMS</b>  |  |                                  |                                    |   |   | 14. MOTHER'S MAIDEN NAME<br><b>EMMA (DEAY)</b>   |                      |   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |  |                                  |                                    | 16. SOCIAL SECURITY NO.<br><b>511-30-6685</b>   |   | 17. INFORMANT<br><b>HOSPITAL ADMISSION</b>   |                      |   | Address   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>4201</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |                                  |                                    |   |   |  |                      |   |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |                      |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                                  |                                    | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>                          |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                      | 20f. (City or town) (County) (State)                                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5-26</b> , 19 <b>67</b> , to <b>6-2</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6-2</b> , 19 <b>67</b> , and that death occurred at <b>7 P</b> M, from the causes and on the date stated above.  |  |                                  |                                    |   |   |  |                      |   |   |  |  |
| 22a. SIGNATURE<br><i>[Signature]</i>   |  |                                  |                                    |   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                      |   | 22b. DATE SIGNED<br><b>6-2-67</b>                                 |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>R. M. GELICH</b>  |  |                                  |                                    |   |   | 22d. ADDRESS<br><b>120 N. SMALLWOOD CUMBERLAND MD</b>  |                      |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                                  | 23b. DATE THEREOF<br><b>6/5/67</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Deay Cemetery</b>  |  |                      | 23d. LOCATION (City, town or county) (State)<br><b>Vinland Kansas</b> |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>H. Lee Silcox 404 Decatur St Cumberland, Md</b>   |  |                                  |                                    |   |   | 25a. REC'D BY REGISTRAR<br><b>JUN 6 1967</b>   |                      | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                      |   |  |  |

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ALLIANCE

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SACRED BEAT HOSPITAL

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CHARLES W. WILLIAMS

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211-30-2

HOSPITAL ADMISSION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items #8 & 9 Film #G390 8/29/67 pc

07527

CERTIFICATE OF DEATH

07503

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|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Westernport Rt. 1</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Westernport Route 1</b>                                     |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Route 1 Westernport</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Alice First Virginia Middle Paugh Last</b>   |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>13</b> Year <b>1967</b>   |   |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>1897</b><br><b>Sept 14, 1897</b>                    |
| 9. AGE (In years last birthday) <b>69</b> yrs.   |  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Joseph Tasker</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Bane</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>Mrs Ray Mayhew</b>   |  | Address<br><b>Route 1, Westernport</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the cervix with metastasis</b><br><b>171x</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b>                        |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 1B.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                    |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.   |  |  |   |
| 22a. SIGNATURE<br><b>Phillip G. Stagers</b>  |  | 22b. DATE SIGNED<br><b>6/14/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Phillip Stagers, M.D.</b>   |  | 22d. ADDRESS<br><b>Keyser, W.Va.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>June 16, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Philos Cem.</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Westernport Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>E.D. Boud</b>   |  | 25. REGISTRATION SIGNATURE<br><b>Charles Judge</b>   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07528

CERTIFICATE OF DEATH

07504

|  |                                  |  |                                    |
|--|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                  | c. LENGTH OF STAY in 1b<br><b>6 DAYS</b>   |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>   |                                  | d. STREET ADDRESS<br><b>113 UTAH AVENUE</b>  |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHARLES</b> Middle <b>E.</b> Last <b>PFEIFFER</b>  |                                  | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>5</b> Year <b>1967</b>  |                                    |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-13-77</b> |
| 9. AGE (In years last birthday)<br><b>89</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Celanese (Ret)</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Textile</b>  |                                    |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>PENNSYLVANIA</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                    |
| 13. FATHER'S NAME<br><b>CHRISTOPHER PFEIFFER</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>CHRISTINA WHITE</b>   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.  |                                    |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>   |                                  | Address  |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4221</b> <b>Thrombemia</b><br>DUE TO (b) <b>Myocarditis &amp; Decompensation</b><br>DUE TO (c) <b>Atherosclerosis</b>  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 weeks</b><br><b>10 yrs</b>  |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>o.m.</b> <b>19</b><br>p.m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 1965</b> to <b>June 5, 1967</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>3:15 P.M.</b> from causes and on the date stated above. |                                  |  |                                    |
| 22a. SIGNATURE<br><b>Clayton Durrett</b>   |                                  | 22b. DATE SIGNED<br><b>June 6, 1967</b>  |                                    |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR. CLAY E. DURRETT</b>   |                                  | 22d. ADDRESS<br><b>CUMBERLAND, MD</b>  |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>6/8/67</b>   |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Palo Alto Cemetery</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Palo Alto Penna</b>  |                                    |
| 24. FUNERAL DIRECTOR<br><b>Philip B. Wendt 121 Mem. Ave., Cumb., Md.</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JUN 9 1967</b>   |                                    |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                  |  |                                    |

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

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ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

DATE 11-13-77 BY SP-10

CHANDLER

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CHANDLER

MEMORIAL HOSPITAL

1125 UTAH AVENUE

CHANDLER

PRELIMINARY

DATE

WHITE

7-12-77

BY

CHANDLER (S)

CHANDLER

CHRISTOPHER PRELIMINARY

CHRISTOPHER PRELIMINARY

MEMORIAL HOSPITAL, CHANDLER, MD.

2:14 PM

CHANDLER, MD

DR. CRYSTAL CHANDLER

6/2/77

10/1/77

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |                                  |   |   |  |
|---|--|--|--|---|---|----------------------------------|---|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |                                  |   |   |  |
| 07529   |  |  |  | CERTIFICATE OF DEATH  |   |                                  | 07505   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b><br>MARYLAND  |  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |                                  |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |  |  | c. LENGTH OF STAY IN lb<br><b>8 DAYS</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>                                       |                                  |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>  |  |  |  |   | d. STREET ADDRESS<br><b>241 VALLEY ST.</b>  |                                  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>GRACE</b> Middle <b>MAY</b> Last <b>PLUMMER</b>   |  |  |  |   | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>26</b> Year <b>1967</b>  |                                  |   |   |  |
| 5. SEX<br><b>FEMALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>                     |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>3-3-1904</b> |   | 9. AGE (In years last birthday)<br><b>63</b> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b> |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>WEST VIRGINIA U. S. A.</b>  |   |                                  | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b>        |   |  |
| 13. FATHER'S NAME<br><b>JOHN MANUELS</b>  |  |  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>CHARLOTTE KLINE</b>  |                                  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |  |  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>Address<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>   |                                  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4301</b><br>DUE TO <b>Acute Myocardial Infarction</b><br>(b)<br>DUE TO<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 days</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Diabetes mellitus</b>  |  |  |  |   |   |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                 |   |   |                                  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>  |  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)                  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6-19-1967</b> to <b>6-26-1967</b> that (I) (we) last saw the deceased alive on <b>6-26-1967</b> , and that death occurred at <b>8:00 p.m.</b> from causes and on the date stated above.  |  |  |  |   |   |                                  |   |   |  |
| 22a. SIGNATURE<br><b>DR. WYAND F. DOERNER JR</b>  |  |  |  |   | 22b. DATE SIGNED<br><b>6-29-67</b>  |                                  |   | 22c. PHYSICIAN'S NAME (Type)<br><b>DR. WYAND F. DOERNER JR</b>                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |  | 23b. DATE THEREOF<br><b>6-29-1967</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |                                  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland, Md. Allegany</b>                  |  |
| 24. FUNERAL DIRECTOR<br><b>James F. Scarpelli, Cumberland, Md.</b>  |  |  |  |   | 25a. REC'D BY REGISTRAR<br><b>JUL 3 1967</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b> |   |  |

07500

CERTIFICATE OF DEATH

07500

MARYLAND

MARYLAND

MARYLAND

CUMBERLAND

8 DAYS

CUMBERLAND

US ARMY HOSPITAL

241 VALLEY ST.

JUNE 20

PLUMMER

GRACE

REAR WHITE

11-1-1952

WEST VIRGINIA U. S. A.

CHARLOTTE WILHE

JOHN WANDERS

GENERAL HOSPITAL, CUMBERLAND, MD.

DR. WYAND F. ROEMER JR. CUMBERLAND, D.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07530

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07506

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |  |   |  | c. LENGTH OF STAY IN 1b   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Route #6</b>   |  |   |  | d. STREET ADDRESS<br><b>Route #6</b>  |  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Zelma</b> Middle <b>Mae</b> Last <b>Psimer</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>20th</b> , Year <b>1967</b>  |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 24, 1929</b>                                     |  |
| 9. AGE (In years last birthday)<br><b>38</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Keyser, W. Va.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                  |  |
| 13. FATHER'S NAME<br><b>Harrold R. Harrison</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Delia Roberts</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Fred H. Psimer</b> Address <b>RF #6 Cumberland, Md.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4201</b> <b>CORONARY OCCLUSION, RIGHT</b><br>DUE TO (b) <b>CORONARY THROMBOSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>"</b>   |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)      |  |
| 20f. (City or town) (County) (State)  |  |   |  |   |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.  |  |   |  | 22. DATE SIGNED<br><b>June 20, 1967</b>   |  |   |  |
| EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>CUMBERLAND, MARYLAND</b>                             |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>June 23, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Lawn Memo. Garden</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>LaVale, Md</b>          |  |
| 24. FUNERAL DIRECTOR<br><b>Allen M. Rotruck</b> ADDRESS <b>Keyser, W. Va.</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUN 22 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                          |  |

1030

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
07531 07507

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>   |  |
| c. LENGTH OF STAY IN 1b <b>LIFE</b>   |  | d. STREET ADDRESS <b>NONE</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HARDING</b> Middle <b>RICHARDSON</b> Last   |  | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>8</b> Year <b>19 67</b>   |  |
| 5. SEX <b>MALE</b>  | 6. COLOR OR RACE <b>NEGRO</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>UNKNOWN</b>  |
| 9. AGE (In years last birthday) <b>46 EST.</b>  |  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HANDYMAN</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>VARIOUS</b>   |  |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>UNKNOWN</b>  |  | 14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>   |  | 16. SOCIAL SECURITY NO. <b>UNKNOWN</b>   |  |
| 17. INFORMANT <b>KIGHT FUNERAL HOME</b>   |  | Address <b>CUMBERLAND, MD.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>064.4</b> <b>Brain Abscesses</b><br>DUE TO (b) <b>Septicemia</b><br>DUE TO (c) <b>Lung Abscesses (Colon Bacillus)</b>   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>11 days</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.<br>EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>   |  | 22. DATE SIGNED <b>June 8, 1967</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <b>Cumberland, Md.</b> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   | 23b. DATE THEREOF <b>JUNE 10, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>ALLEGANY COUNTY CEMETERY</b>   | 23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND, MD.</b>                           |
| 24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>   |  | 25a. REC'D BY REGISTRAR <b>JUN 14 1967</b><br>DATE   |  |
|   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>  |  |

01331

1967

June 7

1967

June 7

1967

June 7

1967

June 7

1967

June 7

1967

June 7

1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 12, MARYLAND

07532

## CERTIFICATE OF DEATH

07508

|  |                                  |   |  |   |   |   |                                |
|--|----------------------------------|---|--|---|---|---|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |   |   |                                |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Westernport</b>   |                                  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Westernport</b>                                      |   |   |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>148 Wood St.</b>  |                                  |   |  | d. STREET ADDRESS<br><b>148 Wood Street</b>   |   |   |                                |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>George H Robertson</b>  |                                  |   |  | 4. DATE OF DEATH<br><b>June 3 19 67</b>   |   |   |                                |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 17, 1902</b>                                |   | 9. AGE (In years last birthday)<br><b>65</b> yrs. | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Barber</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Allegany</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                            |                                |
| 13. FATHER'S NAME<br><b>George Robertson</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Maude Wilson</b>   |   |   |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>220-30-5836</b>   |  | 17. INFORMANT<br><b>Mrs. George Robertson Westernport, Md</b>   |   |   |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Embolus</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Artery Disease</b><br>DUE TO<br>(a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |                                  |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 Hours</b><br><b>5 Years</b>    |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |                                |
| 20c. TIME OF INJURY<br>Hour a.m.<br>p.m.   | Month, Day, Year<br><b>19</b>    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town)   | (County)  | (State)   |                                |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 31, 1967</b> to <b>June 3, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 3, 1967</b> , and that death occurred at <b>9:45</b> P.M. from the causes and on the date stated above.  |                                  |   |  |   |   |   |                                |
| 22a. SIGNATURE<br><b>Paul R. Wilson</b> M.D.   |                                  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>             |   | 22b. DATE SIGNED<br><b>June 5, 1967</b>                                 |                                |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Paul R. Wilson M.D.</b>   |                                  |   |  | 22d. ADDRESS<br><b>Ashfield St. Piedmont, W.Va.</b>   |   |   |                                |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>June 7, 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Philos Cemetery</b>  |   | 23d. LOCATION (City, town or county) (State)<br><b>Westernport, Md.</b> |                                |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. A. Fredrickson</b>   |                                  |   |  | ADDRESS<br><b>Piedmont, W.Va.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JUN 7 1967</b>                            |                                |
|  |                                  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |   |                                |

VR A15 (4)  
15M 9/60

07100

07100

Albany

Albany

Albany

Westborough

Westborough

148 Wood Street

148 Wood St.

June 3, 1902

George Robertson

George

May 17, 1902

White

Kate

U.S.A.

Albany

Barber

George Robertson

George Robertson

280-30-1038, Mrs. George Robertson Westborough, Ma

no

Ashtield St. Richmond, W. Va.

Paul M. Wilson M.D.

Westborough, Ma.

June 7, 1902 Hillis Cemetery

Richmond, W. Va.

Richmond, W. Va.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07533

CERTIFICATE OF DEATH

07509

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>65 years</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><del>XXXXXXXX</del> <b>Leon (Lee) ROGAN</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>JUNE 11 19 67</b>  |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 30, 1891</b> |
| 9. AGE (In years last birthday) yrs.<br><b>75</b>   |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Machinist Helper Railroad</b>                      |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Barton, Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Thomas Rogan</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Davis</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>yes War I</b>   |                                  | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>  |                                  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Failure</b><br>4221 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic CV Disease</b><br>DUE TO (c) <b>Also had aneurysm - aorta</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Indefinite</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Operation - 4-2-67 Intestinal Obstruction</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1967 to 10 P.M.</b> , 19 <b>67</b> , that (I) <b>yes</b> last saw the deceased alive on <b>6-11</b> 19 <b>67</b> , and that death occurred at <b>M.</b> from causes and on the date stated above.   |                                  |   |   |
| 22a. SIGNATURE<br><b>Carlton Brinsfield</b>   |                                  | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR. CARLTON BRINSFIELD</b>   |                                  | 22d. ADDRESS<br><b>CUMBERLAND, MD.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>June 14, 1967</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland, Md. Allegany</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>James F. Scarpelli, Cumberland, Md.</b>  |                                  | 25. ISSUED BY REGISTRAR<br><b>JUN 15 1967</b>   |   |
| 26. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1913

CERTIFICATE OF ANALYSIS

7533

DATE MADE

ALLERMAN

INDIAN

CUMBERLAND

OF

CUMBERLAND

7 RYD AVE

EMERALD HOSPITAL

JUNE 11

STATION

1913

STATION

MADE

1913

1913

1913

1913

EMERALD HOSPITAL, CUMBERLAND, D.

DR. CARLTON DRISFIELD

CUMBERLAND, MD.



07534

07534

Memorial Hospital (40 Minutes)  
 11 Madison Ave.  
 30 West  
 11 Madison Ave.  
 30 West

Elizabeth J. Rorick  
 1000 10, 1912  
 1000 10, 1912  
 1000 10, 1912

Daniel Rorick  
 1000 10, 1912  
 1000 10, 1912  
 1000 10, 1912

1000 10, 1912  
 1000 10, 1912  
 1000 10, 1912

1000 10, 1912  
 1000 10, 1912  
 1000 10, 1912

1000 10, 1912  
 1000 10, 1912  
 1000 10, 1912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07535

CERTIFICATE OF DEATH

07511

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |  | c. LENGTH OF STAY IN 1b<br><b>1MO 3WKS 1DA.</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>   |  |   |  | d. STREET ADDRESS<br><b>RT#3, BEDFORD RD.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <b>IRA</b> First <b>C</b> Middle <b>SAVILLE</b> Last   |  |   |  | 4. DATE OF DEATH Month <b>JUNE</b> Day <b>18</b> Year <b>1967</b>  |  |   |  |
| 5. SEX <b>MALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>3-22-1889</b>   |  |
| 9. AGE (In years last birthday) <b>78</b> yrs.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>GROCERY</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>CUMBERLAND, MARYLAND</b>                |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  | 13. FATHER'S NAME<br><b>ISAC SAVILLE</b>   |  |   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>ANNA BARNES</b>   |  |   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>                                     |  |   |  |
| 16. SOCIAL SECURITY NO.<br><b>233 18 4911</b>  |  |   |  | 17. INFORMANT Address<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO (b) <b>Arteriosclerosis</b><br>DUE TO (c) <b>Chronic Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 weeks</b><br><b>5 yrs</b>                                |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work        |  | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)<br><b>Cumby Alley Md</b>                                     |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4/7/67</b> , 19 to <b>4/17/67</b> , 19, that (I) (we) last saw the deceased alive on <b>4/17/67</b> , 19, and that death occurred at <b>4:40 AM</b> , from causes and on the date stated above.   |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><b>[Signature]</b>   |  |   |  | 22b. DATE SIGNED<br><b>4/19/67</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>DR. R. J. WILLIAMS</b>   |  |
| 22d. ADDRESS<br><b>122 SO. CENTRE ST, CUMBERLAND, MD</b>   |  |   |  | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                     |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>June 20, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland, Md.</b>                           |  |
| 24. FUNERAL DIRECTOR<br><b>Byron Kight</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>JUN 23 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

VR A15 (4)  
20 M 1/66

97533

CRIMINAL CASE NO. 100-100000

1961

DAVID L. BROWN

ATLANTA, GA.

CHIEF OF POLICE

ATLANTA, GA.

CHIEF OF POLICE

ATLANTA, GA.

ATLANTA, GA.

ATLANTA, GA.

ATLANTA, GA.

ATLANTA, GA.

ATLANTA, GA.

ATLANTA, GA.

ORIGINAL FILED IN 100-100000

VR A15 (4)  
20 M 1/66

7536

CERTIFICATE OF DEATH

Death from  
Cerebral arteriosclerosis  
Cerebral arteriosclerosis

Deceased male

Jan 10 1908

Jan 10

100 E Main St - Frostburg, Md

Wm H. Frost

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #8 Film #G389 6/11/67 pc

07537

CERTIFICATE OF DEATH

07513

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |  | c. LENGTH OF STAY IN 1b<br><b>79 DAYS</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>  |  | d. STREET ADDRESS<br><b>516 LOWELL AVENUE</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROY</b> Middle <b>T.</b> Last <b>SHAFFER</b>  |  | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>7</b> Year <b>1967</b>   |   |
| SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>1888</b><br><b>11-15-88</b>                         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CARMAN</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>PENNA.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>WILLIAM SHAFFER</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>ELLIA SHIPLEY</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>705 10 8384</b>   |   |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL</b>   |  | Address<br><b>CUMBERLAND, MD.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA-GENERALIZED</b><br><b>177X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PROSTATE</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)<br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>YEARS</b>                        |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <b>L 960</b> to <b>JUNE</b> , 19 <b>67</b> , that (I) (X) last saw the deceased alive on <b>JUNE 7</b> , 19 <b>67</b> , and that death occurred at <b>2:35P</b> M, from causes and on the date stated above.  |  |   |   |
| 22a. SIGNATURE<br><i>[Signature]</i>  |  | 22b. DATE SIGNED<br><b>6-8-67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR. G. OVERTON HIMMELWRIGHT</b>  |  | 22d. ADDRESS<br><b>133 VA. AVENUE, CUMBERLAND, MD.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>JUNE 10, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SUNSET MEMORIAL PARK</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>CUMBERLAND, MD.</b> |
| 24. FUNERAL DIRECTOR<br><b>BYRON KIGHT</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUN 12 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |   |

7-10-67

ALL COUNTY

0156047

CHAMBERLAND, MO.

75 DAYS

CHAMBERLAND

210 LOWELL AVENUE

CHAMBERLAND

JUNE 27

T.

RAY

75

MALE

11-14-65

REMARKS

CHAMBERLAND

ELLEN S. RAY

WILLIAM SHAFER

MEMORIAL HOSPITAL

Y.

METASTATIC CARCINOMA-GENERALIZED

PROSTATE

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

07

CHAMBERLAND

JUNE 2

6-1-67

DR. J. EVERSON RHEUMATISM 133 W. AVENUE, CHAMBERLAND, MO.

JUNE 10, 1967

JUN 1 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07538

CERTIFICATE OF DEATH

07514

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ALLEGANY</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>W. VIRGINIA</b><br>b. COUNTY<br><b>RIDGELEY, W.VA.</b> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>1 DAY</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>   |                                  | d. STREET ADDRESS<br><b>163 MAIN ST.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |   |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>MARY</b><br>Middle<br><b>E</b><br>Last<br><b>SHEPHERD</b>   |                                  | 4. DATE OF DEATH<br>Month<br><b>JUNE</b><br>Day<br><b>6</b><br>Year<br><b>1967</b>   |   |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>7-15-84</b>                              |
| 9. AGE (In years lost birthday)<br><b>82</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months<br><b>2</b><br>Days<br><b>15</b>   | 11. IF UNDER 24 HRS.<br>Hours<br><b>12</b><br>Min.<br><b>00</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>W. VIRGINIA</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>DANIEL STIENBAUGH</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>CHRISTIAN DYCHE</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |   |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL</b>  |                                  | Address<br><b>CUMBERLAND, MD.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular</b><br><b>334X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Disease</b><br>DUE TO<br>(c) _____ |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Church / City</b>   |                                  | 20f. (City or town) (County) (State)<br><b>Cumt / Alleg / Md</b>   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/2/34</b> , 19__, to <b>6/6/67</b> , 19__, that (I) <del>the</del> last saw the deceased alive on <b>6/6/67</b> , 19__, and that death occurred <b>2:45 P.M.</b> from causes and on the date stated above.   |                                  |  |   |
| 22a. SIGNATURE<br><b>DR. R. J. WILLIAMS</b>  |                                  | 22b. DATE SIGNED<br><b>6/8/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR. R. J. WILLIAMS</b>  |                                  | 22d. ADDRESS<br><b>122 S. CENTRE ST., CUMBERLAND, MD.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 23b. DATE THEREOF<br><b>JUNE 9, 1967</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>SUNSET, MEMORIAL PARK</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>CUMBERLAND, MD.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>BYRON KIGHT</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JUN 12 1967</b>  |   |
| ADDRESS<br><b>CUMBERLAND, MD.</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |

MEMORIAL HOSPITAL - CONSUMPTION, MD.

12:45 PM

12:45 PM

W. VIRGINIA

LEGACY

W. VA. RILEY, W. VA.

1 DAY

CONSUMPTION

123 MAIN ST.

MEMORIAL HOSPITAL

63

JUNE 6

SHENANDO

E

W. VA.

7-12-80

WHITE

W. VIRGINIA

U.S.A.

CONSUMPTION

CONSUMPTION

MEMORIAL HOSPITAL - CONSUMPTION, MD.

12:45 PM

W. VA. RILEY, W. VA.

123 MAIN ST.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07539

CERTIFICATE OF DEATH

07515

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ALLEGANY</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b> b. COUNTY<br><b>ALLEGANY</b>           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |   | c. LENGTH OF STAY IN lb<br><b>32 DAYS</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>   |   | d. STREET ADDRESS<br><b>183 S. WATER ST.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>FREDERICK H SHOCKEY</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>JUNE 25 1967</b>   |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-22-00</b>  |
| 9. AGE (In years lost birthday)<br><b>66 yrs.</b>  |   | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SELF-EMPLOYED</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>TAVERN OPERATOR</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>PENNA.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>HERMAN SHOCKEY</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>SUSAN WARNER</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |   | 16. SOCIAL SECURITY NO.<br><b>215-18-8513</b>   |   |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL</b>  |   | Address<br><b>CUMBERLAND, MD.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatous</b><br>DUE TO (b) <b>Carcinoma - transitional cell-bladder</b><br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Abscess &amp; infection retroperic space -</b>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5/29 1967</b> to <b>6/25 1967</b> , that (I) (we) last saw the deceased alive on <b>6/24 1967</b> , and that death occurred <b>10:35 AM</b> , from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><b>W. Himmler</b>  |   | 22b. DATE SIGNED<br><b>6/27/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR. WALTER HIMMLER</b>  |   | 22d. ADDRESS<br><b>CUMBERLAND, MD.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>JUNE 28, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WHITE OAK CEMETERY</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>SOMERSET, PENNA.</b>                          |
| 24. FUNERAL DIRECTOR<br><b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JUN 29 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |

07312

STATE OF DEATH

07312

|                       |  |                        |  |
|-----------------------|--|------------------------|--|
| NAME OF DECEASED      |  | DATE OF DEATH          |  |
| JAMES H. HARRIS       |  | JAN 21 1941            |  |
| AGE                   |  | SEX                    |  |
| 68                    |  | M                      |  |
| BIRTH DATE            |  | BIRTH PLACE            |  |
| JAN 1 1873            |  | NEW YORK               |  |
| OCCUPATION            |  | CAUSE OF DEATH         |  |
| FARMER                |  | HEART DISEASE          |  |
| RESIDENCE             |  | PLACE OF DEATH         |  |
| 123 MAIN ST. NEW YORK |  | NEW YORK               |  |
| SIGNATURE OF DECEASED |  | SIGNATURE OF WITNESSES |  |
| [Signature]           |  | [Signature]            |  |
| DATE                  |  | PLACE                  |  |
| JAN 21 1941           |  | NEW YORK               |  |
| REGISTRY              |  | OFFICIAL               |  |
| [Signature]           |  | [Signature]            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #3 Film #G390 8/26/67 pc

07540

CERTIFICATE OF DEATH

07516

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ALLEGANY</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>ALLEGANY</b>        |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>1WK. 1DAY</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>   |                                  | d. STREET ADDRESS<br><b>OLDTOWN, MD.</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>LORENA</b>  |                                  | 4. DATE OF DEATH<br>Month<br><b>JUNE</b><br>Day<br><b>15</b><br>Year<br><b>1967</b>   |  |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 4, 1895</b> |
| 9. AGE (In years lost birthday)<br><b>72 yrs.</b>  |                                  | IF UNDER 1 YEAR<br>Months<br>Days<br>Hours<br>Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>WIFE.</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>OLDTOWN, MD.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>CHARLES TWIGG</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>HANNAH SALESBOROUGH Goldsborough</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br><b>4201</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Hypertensive Arterio</b><br>DUE TO<br>(c) <b>Sclerotic C.V.D.</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>Since</b><br><b>1960.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetes Mellitus - severe</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour 'o.m.<br>p.m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3-22-1967</b> to <b>5-15-1967</b> , that (I) (we) last saw the deceased alive on <b>5-14-1967</b> , and that death occurred at <b>5:00A.M.</b> from causes and on the date stated above.  |                                  |   |  |
| 22a. SIGNATURE<br><b>Wm. F. Williams M.D.</b>  |                                  | 22b. DATE SIGNED<br><b>5-15-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR. WM. F. WILLIAMS</b>   |                                  | 22d. ADDRESS<br><b>122 S. CENTRE ST. CUMBERLAND, MD.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>6-18-67</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Davis Memorial Cemetery</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Scarpelli Funeral Home</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>JUN 20 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>James J. Scarpelli</b>  |                                  | 25c. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

073500

STATE OF OHIO

1910

ALLIANCE

MARYLAND

ALLIANCE

THE DAY

CHURCH

THE DAY

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

DR. W. T. WILLIAMS

122 S. CENTRE ST. CHILDEEN AND CO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the ban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07541

CERTIFICATE OF DEATH

07517

|   |                                  |   |                                       |
|---|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>ALLEGANY</b>              |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>2 DAY 8 HR</b>  |                                       |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |                                  | d. STREET ADDRESS<br><b>21 CRESAP DR., BOWLING GREEN</b>  |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>EVELYN MAE SMITH</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>JUNE 21 19 67</b>  |                                       |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-01-1907</b> |
| 9. AGE (In years last birthday)<br><b>59 yrs.</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                       |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machine Opr.</b>  |                                  | 11b. KIND OF BUSINESS OR INDUSTRY<br><b>Factory Wkr.</b>  |                                       |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>MONONGAHELA CITY, PA.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                       |
| 13. FATHER'S NAME<br><b>JOHN JAMES CALVERT</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>FLORENCE ANN WESTWOOD</b>  |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>215-20-6833</b>   |                                       |
| 17. INFORMANT<br>Address<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>   |                                  |   |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septal infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Coronary thrombosis</b><br>DUE TO<br>(c) <b>Arterio Sclerotic Coronary Artery disease</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>1 day</b><br><b>6 mos</b>  |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Latent diabetes mellitus, Vaginal repair procedure</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 18, 1967</b> to <b>June 21, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 20, 1967</b> , and that death occurred at <b>2:55 AM</b> from causes and on the date stated above.  |                                  |   |                                       |
| 22a. SIGNATURE<br><b>D. B. GROVE, MD.</b>   |                                  | 22b. DATE SIGNED<br><b>JUN 25 1967</b>  |                                       |
| 22c. PHYSICIAN'S NAME (Type)<br><b>D. B. GROVE, MD.</b>   |                                  | 22d. ADDRESS<br><b>122 SOUTH CENTRE STREET CUMBERLAND, MD.</b>  |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>6/24/67</b>   |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland, Allegany, Md.</b>   |                                       |
| 24. FUNERAL DIRECTOR<br><b>H, Wayne George Cumberland, Md.</b>  |                                  | 25a. REG. BY REGISTRAR<br><b>JUN 25 1967</b>  |                                       |
|   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                       |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07542

07518

FOR STATE HEALTH DEPT.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland,</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland,</b> 011  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>D. O. A. Memorial</b>   |  | d. STREET ADDRESS<br><b>237 Paca St.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ollie</b> Middle <b>Frances</b> Last <b>Snyder</b>   |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>27</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>Feb. 18, 1890</b> 77 yrs.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife,</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Monterey, Virginia</b>                            |
| 13. FATHER'S NAME<br><b>Henry Grogg</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Barbara Sponaugle</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No,</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  | 17. INFORMANT<br><b>Mrs. Elva Walters, 237 Paca St, Cumb. Md.</b>                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b><br>DUE TO <b>11201</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO (b) <b>CORONARY SCLEROSIS</b><br>DUE TO (c) <b>---</b>   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>SUDDEN</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6/27/67<br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rt. # 9<br>Address (Street, city, town, or county) <b>Cumberland, Md.</b> |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>7/1/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland, Allegany Md.</b>                  |
| 24. FUNERAL DIRECTOR<br><b>H. Wayne George Cumberland, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 30 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |

TO-DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in place of the word "deceased". Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07543

07519

|  |                                  |   |                                      |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>W. Va.</b> b. COUNTY <b>Mineral</b>                    |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Ridgeley</b>   |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Memorial Hosp. (D.O.A.)</b>   |                                  | d. STREET ADDRESS<br><b>168 Main St.</b>  |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>Robert</b> Last <b>Spangler</b>  |                                  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>8</b> Year <b>19 67</b>  |                                      |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/16/1899</b> |
| 9. AGE (In years)<br>lgt birthday <b>68</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>19</b> Hours <b>67</b> Min.  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Textile Plant</b>   |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>Cumberland, Md.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                      |
| 13. FATHER'S NAME<br><b>Robert P. Spangler</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Snyder</b>  |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes W.W. # 1</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>214-07-0005</b>   |                                      |
| 17. INFORMANT<br><b>Mrs. Hallie Spangler</b>   |                                  | Address <b>Ridgeley, W. Va. 168 Main St.</b>  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4201</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CORONARY OCCLUSION</b><br>(c) <b>CORONARY SCLEROSIS</b>   |                                  | INTERVAL BETWEEN DEATH AND EXAMINATION<br><b>SUDDEN</b><br><b>---</b>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |                                      |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |                                      |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b>  |                                  | M.D. <b>6-8-67</b>  |                                      |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>  |                                  | 22. DATE SIGNED <b>6-8-67</b>   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>6/12/67</b>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Davis Memorial Burial Park</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland, Allegany, Md.</b>   |                                      |
| 24. FUNERAL DIRECTOR<br><b>H. Wayne George</b>   |                                  | ADDRESS <b>Cumberland, Md.</b>  |                                      |
| 25a. REC'D BY REGISTRAR<br><b>JUN 14 1967</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                      |

7543

Allegany

Chesapeake

Howard's No. 1, 1911

1911

Robert

Robert

Robert

June

Wicks

Wicks

5/10/1899

35

Terrell's Plant

Combs, W.

U.S.A.

Robert F. Souders

May 1911

Yes

W.D. 1

11-1-1903

W.D. 1903

Shirley

Shirley

CONWAY 211-1212

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George's No. 1, 1911

George's No. 1, 1911

George's No. 1, 1911

George's No. 1, 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07544

## CERTIFICATE OF DEATH

07521

|   |                                  |   |   |   |   |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>1WK, 1DAY, 9HRS.</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>MT. SAVAGE</b> 011                                   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>  |                                  |   | d. STREET ADDRESS<br><b>MT. SAVAGE</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HOWARD</b> Middle <b>R.</b> Last <b>STEVENS</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>29</b> Year <b>1967</b>  |   |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-7-1895</b>   |   | 9. AGE (In years lost this day)<br><b>72</b> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>FROSTBURG, MARYLAND</b>           |   |
| 13. FATHER'S NAME<br><b>GEORGE STEVENS</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>CATHERINE HAGER</b>  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>712-14-1699</b>   |   | 17. INFORMANT Address<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>                          |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Disease</b><br>334X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b><br>DUE TO<br>(c) |                                  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1-72</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)<br><b>Uremia</b>  |                                  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Camp Alleg MD</b> |   |
| 20f. (City or town) (County) (State)<br><b>Camp Alleg MD</b>  |                                  |   |   |   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6/27/67</b> , 19___, to <b>6/29/67</b> , 19___ (that I) (we) last saw the deceased alive on <b>6/29/67</b> , 19___, and that death occurred at <b>11:50</b> AM, from causes and on the date stated above.  |                                  |   |   |   |   |
| 22a. SIGNATURE<br><b>[Signature]</b>  |                                  | ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |   | 22b. DATE SIGNED<br><b>7/2/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR. R.J. WILLIAMS</b>  |                                  | 22d. ADDRESS<br><b>122 SO. CENTRE STREET, CUMBERLAND, MD</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>JULY 2, 1967</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FROSTBURG MEM. PARK</b>                            |   |
| 23d. LOCATION (City or Town) (County) (State)<br><b>FROSTBURG ALLEG. MD</b>   |                                  |   |   |   |   |
| 24. FUNERAL DIRECTOR<br><b>JOHN J. HAGER, JR.</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JUL 5 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |

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THE STATE OF DEATH

LEGACY

BY AND

COUNTY OF

MINNAPOLIS

HOWARD

WHITE

RETIRED

ENCLOSURE

CARRIAGE

REPAIRS

REPAIRS

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REPAIRS

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07545

07522

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |  | c. LENGTH OF STAY IN 1b<br><b>2 HRS</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Memorial Hosp.</b>  |  | d. STREET ADDRESS<br><b>225 BEDFORD ST.</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Baby</b> Middle <b>Girl</b> Last <b>TALLMAN</b>  |  | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>7</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-7-67</b>   |
| 9. AGE (In years lost birthday) yrs.<br><b>2</b>   |  | IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>2</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None, (infant)</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>CUMBERLAND, MD.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>JAMES E. TALLMAN</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>BONNIE *MALONE Bonita Malone</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL</b>  |  | Address<br><b>CUMBERLAND, MD.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Preventable Premature</b><br><b>776X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____ |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>6:15A</b> M, from causes and on the date stated above.  |  |   |   |
| 22a. SIGNATURE<br><b>Leland Ransom</b>   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             | 22b. DATE SIGNED<br><b>7 June 67</b>  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR. LELAND RANSOM</b>   |  | 22d. ADDRESS<br><b>CUMBERLAND, MD.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>6/8/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Ashby Cem.</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Fort Ashby, Mineral W. Va.</b>                |
| 24. FUNERAL DIRECTOR<br><b>H. Wayne George Cumberland, Maryland</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUN 12 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

UNITED STATES DEPARTMENT OF JUSTICE

7-25-67

ALLEGEDLY

MARYLAND

CUMBERLAND

S. 402

CUMBERLAND, MD.

Investigation Report

202 8000 RD. ST.

Subject

JAILMAN

JAMES

PRISON WHITE

Prison (Prison)

CUMBERLAND, MD.

Prison

IRVING E. JAILMAN

Prison (Prison)

Prison (Prison)

Prison

Prison

Prison (Prison)

CUMBERLAND, MD.

Prison (Prison)

Prison (Prison)

Prison (Prison)

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07546

07523

|  |                                  |   |  |   |   |   |                                |
|--|----------------------------------|---|--|---|---|---|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |   |   |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FROSTBURG</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>D O A</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ECKHART</b>  |   | d. STREET ADDRESS<br><b>21-1</b>  |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MINERS HOSPITAL</b>   |                                  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |                                |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARIE</b> Middle <b>S.</b> Last <b>VALENZANO</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>15</b> Year <b>19 67</b>   |   |   |                                |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>DEC. 28, 1881</b> |   | 9. AGE (In years last birthday) yrs.<br><b>85</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSE WORK</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>TORINO, ITALY</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                |
| 13. FATHER'S NAME<br><b>JOSEPH P. SASSONE</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>MATILDA GAVIATI</b>  |   |   |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>(If yes give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>213-09-6584-D</b>   |  | 17. INFORMANT Address<br><b>LOUIS VALENZANO, ECKHART, MD.</b>   |   |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4201</b> <b>Coronary Occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b><br>DUE TO<br>(c)  |                                  |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>   |                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetes</b>   |                                  |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |                                |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |  |   |   |   |                                |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b><br>EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>   |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                       |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 23b. DATE THEREOF<br><b>6-19-67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. MICHAELS CEMETERY</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>FROSTBURG, MD.</b>                            |                                |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>  |                                  |   |  | 25a. REC'D BY REGISTRAR<br><b>JUN 20 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                |

22. DATE SIGNED  
**June 15, 1967**

Address (Street, city, town, or county)  
**Cumberland, Md.**

0250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07547

CERTIFICATE OF DEATH

07524

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |  | c. LENGTH OF STAY IN 1b<br><b>1 WK. 1/2 DAY</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL, CUMBERLAND</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) <b>ROBERT</b> First Middle (Vandegrift) <b>W. VANDEGRIFT</b>   |  | 4. DATE OF DEATH <b>JUNE 17, 19 67</b> Month Day Year  |  |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>3-7-1917</b> 9. AGE (In years lost birthday) <b>50</b> yrs.      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>VIKING INC.</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>CUMB, MD.</b>  |  |
| 13. FATHER'S NAME (Vandegrift) <b>WILLIAM H. VANDEGRIFT</b>  |  | 14. MOTHER'S MAIDEN NAME <b>MARY L. SMITH</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>211-05-6001</b>   |  |
| 17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>  |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL EDEMA</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>PATHOLOGIC INTOXICATION WITH EPILEPTOID COMPLICATIONS</b><br>DUE TO<br>(c) <b>ACUTE-CHRONIC- ALCOHOLISM</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 DAYS</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>JUNE 10, 1967</b> to <b>JUNE 17, 1967</b> , that (I) (X) last saw the deceased alive on <b>JUNE 16, 1967</b> , and that death occurred at <b>12:23 AM</b> from causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE <b>DR. G. OVERTON HIMMELWRIGHT</b>  |  | 22b. DATE SIGNED <b>JUNE 17 1967</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>DR. G. OVERTON HIMMELWRIGHT</b>  |  | 22d. ADDRESS <b>133 VIRGINIA AVENUE, CUMBERLAND, MD.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>6/19/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Allegany Maryland</b> |
| 24. FUNERAL DIRECTOR <b>H. Lee Silcox Cumberland, Maryland 21502</b>   |  | 25a. FILED BY REGISTRAR <b>JUN 20 1967</b> 25b. REGISTRAR'S SIGNATURE <i>Rebecca Juage</i>   |  |

025242

INSTITUTE OF HEALTH

ALLEGANY

WARRS AND

ALLEGANY

C. VERBERG

W. W. M. DAY

C. VERBERG

MEMORIAL HOSPITAL, CLEVELAND

104 NICHOLAN AVE.

W. W. M. DAY

ROBERT

3-1111

WHITE

USA

CLUB

VIRGINIA

W. W. M. DAY

WILLIAM J. HANDBERG

ST. CLEVELAND

MEMORIAL HOSPITAL, CLEVELAND

7 DAYS

DEPARTMENT OF

PATHOLOGIC INTOXICATION WITH EPILEPTIC

COMPLICATIONS

ACUTE-CHRONIC-ALCOHOLISM

4/15/58

Seventy

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

07548.

**CERTIFICATE OF DEATH**

07525

|  |  |  |   |   |  |  |   |
|--|--|--|---|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |  |  | c. LENGTH OF STAY IN 1b<br><b>67 DAYS</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FROSTBURG</b> |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>   |  |  |   | d. STREET ADDRESS<br><b>LOWER CONSOLE RD.</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>MARY E. WALBERT</b>   |  |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>JUNE 2, 19 67</b>  |  |  |   |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>   |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>6-24-1885</b>   |   |
| 9. AGE (In years last birthday)<br><b>81</b> yrs.  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSE WIFE</b> |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>GILMORE, MARYLAND</b>        |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 13. FATHER'S NAME<br><b>SAMUEL BEAMAN</b>  |   |   |  | 14. MOTHER'S MAIDEN NAME<br><b>HESTER EDWARDS</b>                                      |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>4201</b>   |  |  |   | 16. SOCIAL SECURITY NO.<br><b>213-09-6589A</b>  |  | 17. INFORMANT Address<br><b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>                    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br><b>4201</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Subacute Myocardial Infarction</b><br>DUE TO<br>(c) <b>Arteriosclerotic cardiovascular disease</b> |  |  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>7 weeks</b><br><b>years</b>               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Carcinoma of the bladder (urinary)</b>  |  |  |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work           |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>March 27, 1967</b> to <b>June 2, 1967</b> , that (I) (we) lost the deceased alive on <b>June 2, 1967</b> , and that death occurred at <b>8:25 A.M.</b> from causes and on the date stated above.  |  |  |   |   |  |  |   |
| 22a. SIGNATURE<br><i>Wyand F. Doerner, Jr.</i>   |  |  |   | 22b. DATE SIGNED<br><b>June 5, 1967</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>DR. WYAND F. DOERNER, Jr.</b>                       |   |
| 22d. ADDRESS<br><b>414 N. MECHANIC ST., CUMBERLAND, MD.</b>  |  |  |   | 22e. REC'D BY REGISTRAR<br><b>JUN 7 1967</b>  |  |  |   |
| 23a. BURIAL, CREMATION, or other disposal (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>JUNE 4 '67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>F.B.G. MEMORIAL PARK</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>FROSTBURG, MD.</b>                 |   |
| 24. FUNERAL DIRECTOR<br><b>JOSEPH R. DURST, SR.,</b>   |  |  |   | ADDRESS<br><b>FROSTBURG, MD.</b>  |  | 25a. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                                     |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7588

CERTIFICATE OF MARRIAGE

MADE BY STATE DEPARTMENT OF HEALTH  
ON THE BASIS OF THE RECORDS OF THE  
BUREAU OF VITAL RECORDS AND THE  
BUREAU OF HEALTH STATISTICS

ALLIANCE

MARYLAND

CUMBERLAND

FROSTBURG

MEMORIAL HOSPITAL

LOWER CONSUME NO.

MARY

E.

WARRICK

JOHN

WHITE

10-24-1902

31

WOMAN

ONE DAY

GILMORE, MARYLAND

USA

CAROL BEAMAN

WITNESSES

10-24-1902

Non-Resident of the District

Subject of this Information

Medical Record of the Patient

Operation of the Bladder (Ureter)

June 2, 1902

June 2, 1902

X

DR. WYAND F. WOODRUP, JR., M.D., 1000 10th St., CLEVELAND.

June 2, 1902

CLEVELAND, OHIO

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07543

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07526

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |   | c. LENGTH OF STAY IN 1b<br><b>45 years</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Residence-Mexico Farms</b>  |   | d. STREET ADDRESS<br><b>Mexico Farms</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LENWOOD</b> Middle <b>WALKER</b> Last  |   | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>25</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 10, 1887</b> |
| 9. AGE (In years last birthday)<br><b>80</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <b>01</b> Days <b>1</b> Hours <b>00</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Carman</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Points of Rock, Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Eli Walker</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Barrett</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |   | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Mr. Raymond C. Walker Mexico Farms</b>   |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b><br><b>H201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b><br>DUE TO (c)   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>SUDDEN</b><br><b>----</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)     |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |   |  |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic, M.D.</b>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   | 23b. DATE THEREOF<br><b>June 28, 1967</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland, Md. Allegany</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>James F. Scarpelli, Cumberland, Md.</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUN 27 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   | 25c. DATE SIGNED<br><b>June 25, 1967</b>  |  |

1937

Demetrius H. Hester

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed in any event, within 72 hours after death.

1

(M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07550

CERTIFICATE OF DEATH

07527

|  |                              |   |  |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Garrett</u>                       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Frostburg</u>   |                              | c. LENGTH OF STAY IN 1b<br><u>4 Days</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Miner's Hospital</u>  |                              | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Ada May Wilburn</u>  |                              | 4. DATE OF DEATH<br>Month <u>June</u> Day <u>14</u> Year <u>19 67</u>   |  |
| 5. SEX<br><u>F.</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 3, 1886</u> |
| 9. AGE (In years lost birthday)<br><u>81</u> yrs.  |                              | 10. IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>   |  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                              | 12. BIRTHPLACE (County & State, or foreign country)<br><u>Jennings, Md.</u>   |  |
| 13. FATHER'S NAME<br><u>Charles Hoover</u>   |                              | 14. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>---</u>   |  |
| 17. INFORMANT<br><u>Denzil Wilburn, Grantsville, Md.</u>   |                              | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE BRAIN SYNDROME</u><br>334X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>CIRCULATORY DISTURBANCE</u> DUE TO<br>(c) <u>CEREBRAL ARTERIOSCLEROSIS</u> |                              | INTERVAL BETWEEN ONSET AND DEATH<br><u>7 days</u><br><u>5 YEARS</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <u>19</u><br>p.m.  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 9</u> , 19 <u>67</u> , to <u>June 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 13</u> , 19 <u>67</u> , and that death occurred at <u>1:00 AM</u> , from causes and on the date stated above.   |                              |   |  |
| 22a. SIGNATURE<br><u>A. Paige Strong</u>   |                              | 22b. DATE SIGNED<br><u>June 14, 1967</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)   |                              | 22d. ADDRESS  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                              | 23b. DATE THEREOF<br><u>6/16/67</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Hoover Cemetery</u>   |                              | 23d. LOCATION (City or Town) (County) (State)<br><u>Grantsville, Garrett, Md.</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>Kurt Newman</u>   |                              | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>   |  |
| 25b. REGISTRAR'S SIGNATURE   |                              | 25c. DATE<br><u>JUN 16 1967</u>   |  |

02250

Автоматизация

Circulatory Disturbance

Cerebral Arteriosclerosis

James P. 9 small CS 43 small

78 Elmer

2. 1. 1900

—

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07551

CERTIFICATE OF DEATH

07528

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |  | c. LENGTH OF STAY IN 1b<br><b>11/3/1958</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Allegany County Infirmary</b>   |  | e. STREET ADDRESS<br><b>645 Columbia Avenue</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elizabeth</b> Middle <b>Rebecca</b> Last <b>Wilkins</b>  |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>10</b> , Year <b>19 67</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/18/1882</b>   |
| 9. AGE (In years last birthday)<br><b>84</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   |   |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 12. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   |
| 13. BIRTHPLACE (County & State, or foreign country)<br><b>West Virginia</b>  |  | 14. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |
| 15. FATHER'S NAME<br><b>George Washington Shaw</b>   |  | 16. MOTHER'S MAIDEN NAME<br><b>Marcella J. Sharp</b>  |   |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  | 18. SOCIAL SECURITY NO.<br><b>220-03-7193</b>   |   |
| 19. INFORMANT <b>P.O. Box 599, Allegany County Infirmary records.</b>  |  | Address <b>Cumberland, Md.</b>  |   |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br><b>4200</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial failure</b><br>DUE TO (c) <b>Generalized Arteriosclerosis</b> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>yes</b>                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11/3/58</b> , 19__ to <b>6/10/67</b> , 19__, that (I) (we) last saw the deceased alive on <b>6/9/67</b> , 19__, and that death occurred at <b>8:00</b> M, from causes and on the date stated above.   |  |   |   |
| 22a. SIGNATURE<br><b>George M. Simons</b>  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>       | 22b. DATE SIGNED<br><b>6/10/1967</b>  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>George M. Simons, M. D.</b>   |  | 22d. ADDRESS<br><b>Memorial Hospital, Cumberland, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>Jun. 12, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Allegany Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>William G. Kight</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUN 14 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |   |

1947

Allegany

Maryland

Allegany

Allegany

11/21/53

Allegany

Old Columbia Avenue

Allegany County Jail

Elizabeth Hobbes

William

June 10, 1953

Female White

1

12/18/1953

21

Honolulu

in 1953

West Virginia

Maryland, D. Sharp

George Washington Shaw

Allegany County Jail

12-03-1953

George M. Simons, M. D.

Memorial Hospital, Cumberland, Md.

12/18/53

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM (5)  
5M 1/65

07552

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07529

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |  |   |  | c. LENGTH OF STAY IN ID<br><b>Cumberland Maryland</b>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Sacred Heart Hospital D.O. A.</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Thomas Edward Williamson</b>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>June 17 1967</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>March 4, 1911</b>                                    |  |
| 9. AGE (In years last birthday)<br><b>56 yrs.</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ass't Vice President, Kelly Springfield</b>               |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Thomas, West Virginia</b>           |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U. S. A.</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |   |  |
| 13. FATHER'S NAME<br><b>Arthur Williamson</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Edith Davis</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>Wife: Clara A Williamson, Cumberland, Md.</b>   |  |   |  |
| 17. INFORMANT<br><b>Wife: Clara A Williamson, Cumberland, Md.</b>   |  |   |  | Address   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis, Left</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO (b) <b>Coronary Sclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)          |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)      |  |
| 20f. (City or town) (County) (State)  |  |   |  |   |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b>   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>   |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 17, 1967</b>  |  |   |  |
|   |  |   |  | Address (Street, city, town, or county) <b>Cumberland, Maryland</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>June 20, '67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Peters &amp; Pauls</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Cumberland, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Lewis Stein, Inc.</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>JUN 21 1967</b>   |  |   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |

0753

Allegany Maryland  
Camdenland Maryland

Sacred Heart Hospital L.O.A. 1304 National Highway

Thomas Edward Williamson  
March 1, 1911 30  
Male White

Asst Vice President, Kelly Springfield  
Arthur Williamson  
Edith Davis  
U. S. A. Thomas, West Virginia

no  
Mrs: Clara A Williamson, Camdenland, Md.  
Coronary Thrombosis, left  
Coronary Sclerosis  
Sweden

X X X X X

Burial June 30, 1967 St. Peter's & Paul  
Camdenland, Maryland  
X June 17, 1967  
Benedict Skitarlic, M.D.  
Camdenland, Maryland

Levin Stein, Inc.

VR A15 (4)  
25M 1/67

Item #8 Film #G389 6/8/67 nc

07530

|   |  |                  |  |  |  |   |  |   |  |                            |  |  |  |                  |  |       |  |     |  |      |  |
|---|--|------------------|--|--|--|---|--|---|--|----------------------------|--|--|--|------------------|--|-------|--|-----|--|------|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | ALLEGANY         |  | MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE |  | MARYLAND  |  | b. COUNTY                  |  | ALLEGANY   |  |                  |  |       |  |     |  |      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  |                  |  | CUMBERLAND   |  |   |  | c. LENGTH OF STAY IN 1b                             |  |                            |  | 1WK. 11HRS.  |  |                  |  |       |  |     |  |      |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  |                  |  |  |  |   |  | MEMORIAL HOSPITAL                                   |  |                            |  |  |  |                  |  |       |  |     |  |      |  |
| 3. NAME OF DECEASED (Type or print)   |  |                  |  |  |  |   |  | First   |  | Middle                     |  | Last   |  | 4. DATE OF DEATH |  | Month |  | Day |  | Year |  |
| NINA  |  |                  |  |  |  |   |  | J.  |  | WILSON                     |  | JUNE   |  | 1,               |  | 19    |  | 67  |  |      |  |
| 5. SEX  |  | 6. COLOR OR RACE |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>        |  | 8. DATE OF BIRTH  |  | 9. AGE (In years last birthday)                     |  | 10. IF UNDER 1 YEAR        |  | 10. IF UNDER 24 HRS.   |  |                  |  |       |  |     |  |      |  |
| FEMALE  |  | WHITE            |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                           |  | 5/25-1917/  |  | 49 yrs.   |  | Months                     |  | Days   |  | Hours            |  | Min.  |  |     |  |      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |                  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |   |  | 11. BIRTHPLACE (County & State, or foreign country) |  |                            |  | 12. CITIZEN OF WHAT COUNTRY?   |  |                  |  |       |  |     |  |      |  |
| HWFE.   |  |                  |  | OWN HOME   |  |   |  | KENTUCKY  |  |                            |  | USA  |  |                  |  |       |  |     |  |      |  |
| 13. FATHER'S NAME   |  |                  |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |   |  |                            |  |  |  |                  |  |       |  |     |  |      |  |
| JACK GRACIE   |  |                  |  |  |  | CAMPBELL  |  |   |  |                            |  |  |  |                  |  |       |  |     |  |      |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  |                  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  |   |  |                            |  | Address  |  |                  |  |       |  |     |  |      |  |
| NO  |  |                  |  | 220 10 1848  |  | MEMORIAL HOSPITAL, CUMBERLAND, MD.  |  |   |  |                            |  |  |  |                  |  |       |  |     |  |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  |                  |  |  |  |   |  |   |  |                            |  | INTERVAL BETWEEN ONSET AND DEATH   |  |                  |  |       |  |     |  |      |  |
| 1533 IMMEDIATE CAUSE (a) Metastatic Carcinoma Sigmoid Colon.  |  |                  |  |  |  |   |  |   |  |                            |  | 6 months   |  |                  |  |       |  |     |  |      |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |                  |  |  |  |   |  |   |  |                            |  |  |  |                  |  |       |  |     |  |      |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                  |  |  |  |   |  |   |  |                            |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                  |  |       |  |     |  |      |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |   |  |   |  |                            |  |  |  |                  |  |       |  |     |  |      |  |
| 20c. TIME OF INJURY Month, Day, Year  |  |                  |  | 20d. INJURY OCCURRED   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  | 20f. (City or town)                                 |  | (County)                   |  | (State)  |  |                  |  |       |  |     |  |      |  |
| Hour :00 a.m. 19  |  |                  |  | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>            |  |   |  |   |  |                            |  |  |  |                  |  |       |  |     |  |      |  |
| 21. I certify that (I) (this hospital) attended the deceased from 6/1, 1967, to 6/1, 1967, that (I) (we) saw the deceased alive on 6/1, 1967, and that death occurred at 4:40 A.M. from causes and on the date stated above |  |                  |  |  |  |   |  |   |  |                            |  |  |  |                  |  |       |  |     |  |      |  |
| 22a. SIGNATURE  |  |                  |  | 22b. DATE SIGNED   |  |   |  | 22c. PHYSICIAN'S NAME (Type)                        |  |                            |  | 22d. ADDRESS   |  |                  |  |       |  |     |  |      |  |
| Andrew Stasko   |  |                  |  | 6/1/67   |  |   |  | DR. ANDREW STASKO                                   |  |                            |  | CUMBERLAND, MD.  |  |                  |  |       |  |     |  |      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                  |  | 23b. DATE THEREOF  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)                        |  | (County)                   |  | (State)  |  |                  |  |       |  |     |  |      |  |
| BURIAL  |  |                  |  | JUNE 3, 1967   |  | ZION MEMORIAL PARK**  |  | CUMBERLAND, MD.                                     |  |                            |  |  |  |                  |  |       |  |     |  |      |  |
| 24. FUNERAL DIRECTOR  |  |                  |  |  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR                             |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |                  |  |       |  |     |  |      |  |
| BYRON KIGHT   |  |                  |  |  |  | CUMBERLAND, MD.   |  | DATE JUN 5 1967                                     |  | Charles Judge              |  |  |  |                  |  |       |  |     |  |      |  |

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DEPARTMENT OF HEALTH

ALLEGANY

CLIFTONLAND

MEMORIAL HOSPITAL

133 BOND STREET

WILSON

WIFE

WHITE

NEW YORK

JACK GRACE

555 10TH

10:00 A.M.

DR. ANDREW J. GRACE

10:00 A.M.